UNITED STATES DISTRICT COURT

IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC., Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD., and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD., Defendants.	Case No. 1:12-cv-00560-BLW Bench Trial **Witnesses:** **David C. Pate** **Patricia R. Richards** **William W. Deal** **Marshall F. Priest, III**
FEDERAL TRADE COMMISSION; STATE OF IDAHO, Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A., Defendants.	Case No. 1:13-cv-00116-BLW

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REPORTER'S TRANSCRIPT OF PROCEEDINGS

before B. Lynn Winmill, Chief District Judge

Held on October 8, 2013

Volume 10, Pages 1597 to 1837

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W I T N E S S E S

* * * * *

DEPOSITIONS

P U B L I S H E D

PLAINTIFFS

E X H I B I T S

		ADMITTED
1985	David Pate Article: Hospital-Physician Relations In a Post-Health Care Reform Environment (PLTs' Dep. Ex. 704; SLHS000075064-SLHS000075074)	**1704**
3040	Demonstrative.....	**1790**

DEFENDANTS

E X H I B I T S

		ADMITTED
2640	Saint Alphonsus Health System, Health & Healing, Vol. 3, Winter 2012	**1652**

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PROCEEDINGS

October 8, 2013

***** COURTROOM OPEN TO THE PUBLIC *****

THE CLERK: The Court will now hear Civil Case 12-560-S-BLW, Saint Alphonsus Medical Center, Nampa, Inc., versus St. Luke's Health System for Day 10 of a bench trial.

THE COURT: Good morning, Counsel. I want to -- first of all, it is very nice to have the world not spinning, but I did want to thank counsel for their accommodation of my situation yesterday. And my apologies. It was, obviously, beyond my control, but I know it was terribly inconvenient for everyone, and we will do everything we can to make up for that over the coming days, moving the case along.

My understanding is St. Luke's is ready to call its first witness; is that right? Mr. Bierig?

MR. BIERIG: That is correct, Your Honor. As our first witness, Your Honor, we would call Dr. David Pate. While Dr. Pate is coming, I think I speak for all counsel, both plaintiffs and defendants, in saying that we're very pleased that you're feeling better, and that we're very happy to see you.

THE COURT: I had a bad joke in mind to suggest that one of you sent flowers and candy to my home but not the other.

(Laughter.)

THE COURT: Dr. Pate, could you please step before the clerk and be sworn.

DAVID CHARLES PATE,

having been first duly sworn to tell the whole truth, testified as follows:

THE CLERK: Please take a seat in the witness stand.

Please state your complete name and spell your name for the record.

THE WITNESS: David Charles Pate, D-A-V-I-D, C-H-A-R-L-E-S, P as in Paul, A-T-E.

THE COURT: You may inquire, Mr. Bierig.

MR. BIERIG: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. BIERIG:

Q. Dr. Pate, by whom are you employed?

A. St. Luke's Health System.

Q. What is your position there?

A. President and chief executive officer.

Q. How long have you held that position?

A. Four years as of August 31st.

Q. So that would mean you started August 31, 2009?

A. That is correct.

Q. Can you describe your education starting with college?

A. I graduated from Rice University in Houston in 1979 with a bachelor's degree, and my major was biochemistry. I then went on to medical school, to Baylor College Of Medicine, and I received my medical degree in 1982. I then did my residency training in internal medicine. I then served as a chief medical resident at St. Luke's Episcopal Hospital in Houston and entered private practice when I finished my training. And then subsequently in 1992 I started law school at the University of Houston Law Center, and I graduated in 1996.

Q. And then what did you do after 1996?

A. I had -- I was employed by St. Luke's Episcopal Health System in Houston Texas; no relation to this health system.

Q. And can you describe the nature of your job at St. Luke's Episcopal in Houston?

A. I had numerous positions of progressive and increasing responsibilities. Most recently, before I came here, I was the chief executive officer at St. Luke's Episcopal Hospital, which was the flagship hospital for the system in the Texas Medical Center.

Q. I would like to talk to you about that in a minute. But first of all, I'm going to ask you: While you were doing that, did you have time to write a book on health law?

A. I did. After I graduated from law school my focus was on health law. And I began teaching at the University of Houston Law Center. I taught a course called "Regulation of Healthcare Professionals." And there was not a textbook available, so I took my materials and wrote a textbook of the same name. And that was published in 2002, and then I wrote a supplement to that textbook in 2005.

Q. When you were at St. Luke's Episcopal, what kind of work did you do in your capacities there at St. Luke's Episcopal in Houston?

A. My responsibilities over the range of that time I was there was to develop primary care, work with the independent medical staff. We had about 2,000 independent physicians on the medical staff of that hospital. Worked with them on developing clinical integration, and then ultimately my responsibility was to do that as well as running the hospital.

Q. What sort of steps did you take to try to integrate those 2,000 independent physicians, clinically?

A. We developed an independent practice association or IPA. And over the course of a little more than ten years, worked to try to achieve clinical integration with those physicians.

Q. How successful were your efforts to achieve

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clinical integration with the independent physicians over those ten years?

A. Well, I would say, you know, I am certainly disappointed. I think that we were not able to really achieve the objectives I would have for care coordination, for management of care transitions, for improving health, and we certainly were not able to lower costs.

Q. And why, in your judgment, were your efforts to integrate clinically and achieve the kind of things you just talked about not as successful as you would have liked?

A. Well, unfortunately we had the realities of the reimbursement system, which was purely fee-for-service and -- meaning that it rewarded physicians for everything they did.

The physicians in Texas were very heavily involved in other activities. Many of them had investments in hospitals, surgery centers, imaging centers, laboratories, and unfortunately, the physician's income was based on trying to maximize revenue. And so it became difficult for us to actually control the costs, even while we were able to make some marginal improvements in quality.

THE COURT: Mr. Ettinger.

MR. ETTINGER: Your Honor, I object. Dr. Pate, I think, can talk about his experience, but he's now ascribing motives to a thousand physicians based on the incentives

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they faced, and seems to be a little beyond personal knowledge, Your Honor.

THE COURT: Mr. Bierig.

MR. BIERIG: He was describing, Your Honor, why he feels he was unsuccessful in fully integrating physicians in Houston, clinically. I think it is important to understand later, in terms of his testimony, as to what is trying to be achieved at St. Luke's here in Boise.

THE COURT: I am going to sustain the objection to the extent that the doctor is talking about what specific motivations were. But I think the fee-for-services issue, clearly, is front and center in this case. I think the witness's experience in that regard -- and, again, I think it is probably just an economic reality that the fee-for-services is at least one of the issues that many commentators have been concerned about. And I think all the witness is expressing is that concern, not necessarily trying to ascribe particular motivations to doctors.

So to the extent that it does, I will strike the testimony. But to the extent it's simply a comment about the impact of fee-for-services upon the ability to control costs and coordinate care, I will overrule the objection.

Proceed.

MR. BIERIG: Thank you, Your Honor. I will move on from Houston to Boise.

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BY MR. BIERIG:

Q. Dr. Pate, how did you happen to come to St. Luke's Health System in Boise?

A. I was contacted by a recruiter who suggested that this was the perfect job for me. I had never thought about coming to Idaho, but agreed to come here. And when I came here I saw the incredible opportunity to actually transform healthcare, and that is part of what attracted me here.

Q. When you say you saw an incredible opportunity to transform healthcare, what sort of transformation were you seeking to achieve?

A. Well, what I think, and frankly most all of the experts that I read were in agreement that the current fee-for-service reimbursement system rewards the volume of services provided regardless of outcomes to those who are insured. And I think that's causing our problems, not solving our problems. And I think that we need to transform to a system where all healthcare providers are rewarded based on value, not the volume of services we provide.

Q. How did you become interested in transforming healthcare in the manner that you have just described?

A. The very first time that I really gave this much thought was when President Clinton was in office, and, of course, the national discussion was healthcare reform.

At that time I was a primary care physician -- and

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I might mention, I was a member of the independent practice association I talked about at that time. I was a practicing physician in that organization.

I subsequently took on a position of administration, and so I got to see healthcare from the angle of being a primary care physician and being a hospital administrator. And both of those opportunities gave me the opportunities to see the tremendous opportunity that lied ahead to truly reform healthcare and transform it.

But that was nothing like what happened subsequently when, in 2001, I was diagnosed with cancer and I became a patient, and I got my treatment in the system. And I could see, as a physician, hospital administrator, and patient, how fragmented the healthcare system was; how nobody had all of my information, I had to keep on giving it; how there was no assurance, other than my own kind of checking up on things to make sure that I was getting the evidence-based treatment, the best possible treatment. And it just really fired my interest that we've got to fix this. And frankly, not just for me, but my family all gets care at all the places I work, and I've got to do this for them and my grandchildren and everybody else's grandchildren.

Q. So what did you do to learn about approaches to transforming the delivery of healthcare in the manner that you are speaking about?

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A. Well, first of all, I read everything I can get my hands on. I go to meetings. And at a lot of these meetings I go and network with my colleagues and talk and try to learn from them what's working in different places.

But I have studied looking for what are called "bright spots." Even though there are very disparate health systems across this world, where are the bright spots? Where is something that seems to be working? And then, what can I learn from that?

So obviously we've all heard about the developed economic countries, the European nations. I have looked to see what is the common thread. Why are they getting better outcomes at a lower cost? I have looked at the health systems that I know, from being in healthcare administration, are recognized by my peers as being leading health systems. I've looked at the health systems that President Obama cited at the time of this renewed effort of healthcare reform, organizations like Mayo Clinic, Cleveland Clinic, Geisinger Health System, Kaiser Permanente, the Intermountain Healthcare. I've looked at those organizations and looked for those common themes.

Q. And what was attractive to you about the position at St. Luke's?

A. Well, first of all, the mission, which is to improve the health of people. I really think that the

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long-term answer to the growing healthcare costs is to improve health. And so I really like that.

Second is, when I met with the board, I saw that this board was very knowledgeable, very committed to our communities, and they were passionate about trying to do things that would improve healthcare in Idaho, including our rural areas, and that was attractive to have an opportunity to try to help improve rural healthcare.

And then, finally, all the physicians I met, I was just really very impressed with the quality of physicians in Idaho, as well as their commitment to this. And I thought, boy, with all these ingredients, with an aligned board, with physician leaders, we can do something important here.

Q. How would you describe St. Luke's Health System?

A. You know, I think that early on we were a collection of hospitals. I think now how I would describe us is we are an integrated delivery system.

Q. And what do you mean by that?

A. I mean that it's just not hospitals, it's hospitals and physicians and then all the pieces that are necessary to assemble that care coming together and working together in an integrated fashion to be able to deliver higher quality, more effective care to patients.

Q. And what is the mission of St. Luke's?

A. The mission of St. Luke's Health System is to

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improve the health of the people in the regions we serve.

Q. What is St. Luke's vision of how to achieve that mission?

A. Our vision, to summarize -- and I will tell the vision statement -- but really our vision is accountable care. And by accountable care for St. Luke's we talk about the Triple Aim. And our vision statement is that St. Luke's Health System will transform -- and we picked our words very carefully because we were making this vision statement right before the time that Congress was passing the Affordable Care Act. And we thought it was going to take more than just reform. So we said St. Luke's Health System will transform healthcare by aligning with physicians and other providers to deliver integrated, seamless, patient-centered quality care across all St. Luke's settings.

Q. Was that the vision of St. Luke's when you arrived in August of 2009?

A. It was not. The vision at that time was to be the indispensable provider for the regions we served.

Q. And why did St. Luke's adopt the new vision statement that you talked about?

A. A new CEO would typically look at the mission, vision, and values and make sure those are the right ones to guide an organization forward. I understood how this vision statement had come to be, but I thought it was problematic

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in two regards: One is I didn't think that was really a vision. What does that look like, to be indispensable? Second of all, I didn't think that was a good -- that message would be received by the very people that it is intended for.

I certainly don't want anyone who provides services to me to be indispensable, and I don't think the people of Idaho want St. Luke's to be indispensable. They want us to earn their business every day.

Q. Now, I think you mentioned the Triple Aim. What is the Triple Aim?

A. The Triple Aim for St. Luke's -- there is a number of different versions; this is something that is being increasingly adopted across the country -- but for St. Luke's the Triple Aim is better health, and what we mean is improving the health of people who are not yet patients; better care, improving and coordinating the care for people who are patients; and lower costs, and we mean that the way people would know that is to see that in reduced insurance premiums.

Q. When was the Triple Aim adopted by St. Luke's?

A. I don't remember exactly, but I believe it was in 2011.

Q. What is St. Luke's strategy to achieve the three pillars of the Triple Aim?

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A. You know, I guess I would say four different things:

One is community outreach in order to improve health.

Two is we have to have a system that will provide care to everyone regardless of their ability to pay. And that includes improving access to people who are underserved, who are on Medicaid, who are uninsured; we've got to do those things.

Three, we have to have at a foundation a clinically integrated delivery system that can deliver better care at a lower cost.

And then I think the fourth critical factor is we must have a business model that provides value-based reimbursement to support physicians and hospitals in their efforts to decrease low-value and no-value services that currently are revenue.

Q. I believe, if I heard you correctly, you mentioned four specific strategies. Let's take them one by one. I think the first you mentioned was community outreach. What do you mean by community outreach?

A. So what I am talking about is particularly with respect to how we are going to improve health. And that is something that just has not been addressed by the American healthcare system because we're not paid to improve people's

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health. We're paid to take care of people when they are sick or injured.

If we want to improve the health of people who aren't patients, then you don't look in hospitals and physician offices because that's where patients are. You have to get out in the communities, and that means we've got to get to where those people are, and that's their homes, their schools, and their businesses.

Q. And why is community outreach important, in your view?

A. This is something I talk and write about quite frequently. I don't want to minimize the fact that we have a healthcare crisis today; we do. But frankly I am much more concerned about the healthcare crisis coming, because I think it's of a much greater magnitude. And that is, in large part, related to the epidemic of childhood obesity. And when I was in practice as a general internist, I would see obesity in the 40s and 50s, and then I would see hypertension, high cholesterol, diabetes, heart attacks, and strokes in the 50s and 60s and 70s. What we're seeing now is 15 percent of toddlers, I'm talking about children 2 to 4 years old, that are obese. And this should be shocking news to people. And by the time these children are getting to third grade, 30 percent are obese in Idaho.

And what my concern is -- and it's already

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materializing; I've talked to pediatricians about this, and the American Academy of Pediatrics has already had to respond to this -- what my concern is now we are going to see hypertension, diabetes, heart attacks, and strokes in the teens and 20s and 30s, decades before we saw this before. This has tremendous impacts to the cost of healthcare. These are very expensive conditions, as well as imagine the impact to employers when the workforce is much less healthy. So this is one of my passions.

Now, there's other things that --

Q. Before you go on to other things, what is St. Luke's doing by way of community outreach to address childhood obesity?

A. Not enough because we don't get paid for this. But one of the programs that I'm really proud of that we created together with one of our employed pediatricians who is passionate about this is a program called the "YEAH! program," Y-E-A-H exclamation point. This stands for Youth Engaged in Activities for Health.

And what we're doing is targeting children, 5 to 16, I think it is, that are at the 95th percentile or more of their expected body weight, and we are bringing them, together with their families, into a program where we are teaching them about how to have healthier lifestyles. We have a nutritionist who takes them to the grocery store and

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shows them how to read labels and make healthy choices. We get them together with our social workers and nurses and others, and we get them moving and doing activities.

And what we've seen -- although this is something that we've just piloted and gotten started -- what we've seen is not only are we changing these children's lives, but we're actually impacting their parents, and they are losing weight. Because if you look at these children that are obese, they typically, almost always, have one parent that is also obese, and oftentimes two. So now we can impact a whole family.

And I had the opportunity -- we just -- one of the things we have done to continue to add to our YEAH! program, just this summer we had a YEAH! summer camp. Most of these children had never been to camp; their parents couldn't afford it. And I don't think any of them had ever been to Bogus Basin. But we partnered with Bogus Basin, Walmart, the City of Houston. We took these kids up to camp, and I went up there to see them, and let me tell you, we are changing lives. And these kids who didn't have self-respect, who didn't have self-confidence are now starting to feel better and more confident about themselves.

Q. Does St. Luke's make money on the YEAH! program?

A. No, no. There are some of our community outreach programs that we do get some fees for, and we have partnered

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with the community and gotten some grants, but our investments in community outreach are not made up by these fees. So no, it's an investment we make in our communities.

Q. Well, can you give one or two other examples, very briefly, of other community outreach programs that St. Luke's is doing?

A. A big thing that I am very worried about is smoking, tobacco use. And we were, as a country, making some initial progress in decreasing the smoking rates in young people. And the critical thing at this point seems to be can you prevent a kid from starting to smoke until at least they're 18. The longer you can prevent, the less likely they're going to smoke, and the less likely they're going to have problems. Now we've got these e-cigarettes, and I am very, very worried about what that's going to do.

Q. Does St. Luke's have an outreach program on e-cigarettes?

A. So we have put together programs; we're trying to -- now this is not as advanced as YEAH! yet, but we're going to be getting out there and trying to address tobacco cessation.

Another program that we're very proud of is there's recent evidence showing the harms that are caused to youth and young people engaging in sports who are getting concussions. And so we have made a significant investment

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into a concussion program. And this is an example where we are getting out to schools, and we're helping train athletic trainers and others about how to prevent and manage concussions. And I am very proud of that.

Q. Does St. Luke's make money on the concussion program or the tobacco cessation program?

A. We do not.

Q. Let's turn to the second thing that you mentioned: Why does St. Luke's provide care to all patients regardless of ability to pay?

A. This is a deep commitment we have. We are Idaho's only locally owned, locally governed health system. We are committed to this community, and that means everyone. When I told you about our mission statement and our vision and the Triple Aim, I didn't say that those are just for the people who can afford to pay for them or who are insured. That is the fundamental problem with the traditional fee-for-service system. And these people do not get access to care or they get access only at a very advanced stage in costly settings. So it is very important that we make our programs available to everyone.

Q. Is the commitment of St. Luke's to provide care to all regardless of their ability to pay shared by physician practices that are integrated into St. Luke's?

A. Absolutely, or they don't get integrated into

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St. Luke's.

Q. Now, you said as the third strategy you mentioned clinically integrating the delivery of care. What do you mean by that?

A. What I mean and what we envision at St. Luke's is getting all of the pieces of the health system to come together and work together. And that means, in getting back to the vision statement, we talk about how it's got to be integrated. What we're talking about is having an underlying unified electronic health system where every person who is involved in your care has all the data.

We are talking about making it seamless for patients, meaning that you go one place in the system, you don't have to -- like back in Texas if you went from one provider to another, you actually had to buy your medical records and get them transferred. Now everybody has access to those records; you don't have to reregister. It's bringing all these things together, including how we're going to have to get physicians working a new care model.

We don't have enough physicians in Idaho. And we're adding nurse practitioners and PAs and other people to work together as teams. And let me tell you, I can tell you from my experience, this does not happen naturally. In fact, it doesn't even happen until you put in an awful lot of time and hard work.

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But what we've developed is physician leadership that is amazing. And I never had anything like this in Houston. And physicians who -- we believe are the best people to lead this, to lead this cared redesign and what we're trying to do. We've got that, the unified electronic health record, the investment into analytics to support this, and data help to help guide decisions, and the clinical decision support systems which will be our next step, where we can actually make sure that the physicians have data at their fingertips about what are the best treatments.

And, in fact, this will help address another IOM report that just came out recently talking about the problems in cancer care across this country because it's so fragmented people don't have information, and they are not using best practices.

Q. Well, how does integration, the clinical integration that you just spoke of, how does that allow St. Luke's to offer better care at a lower cost?

A. Several things. First of all, we think there's -- and so do policy-makers -- there's a lot of opportunity just to reduce duplication of things in the healthcare system.

One of the things that happens when this care is so fragmented, you go one place to get your care and that -- and you may have had a test, you go to another physician,

they don't have the test, they just redo it. And I'll tell you what, one of the things that happens, you get a patient, for example, that comes in to see a doctor like me with abdominal pain, gets a CAT scan, gets exposed to radiation and perhaps contrast, that test result is not ready, I leave for the weekend, that patient gets worse, ends up in our emergency room. If we don't have access to that information and that emergency room has to evaluate, they are going to do another CAT scan. It is very expensive. Now you're subjecting the patient to more radiation, maybe more contrast, which can hurt their kidneys. I mean, that is definitely not better care.

So it allows us to avoid duplication. It allows us to reduce unnecessary services, and with the financial alignment that we're trying to get and get the incentives aligned to what we say we want, instead of rewarding volumes of services, now we can look at what's the best treatment that is the least intensive, and therefore least costly, that will still get the same or better results.

Q. Moving on to the fourth strategy, you mentioned payment based on value rather than on volume.

A. Yes.

Q. What did you mean by that?

A. So -- and I will give you an example, but what I'm talking about is a payment system that does not reward

people to just do things, that I'm going to get paid for everything I do, every service I provided, and totally regardless of whether it's the best treatment, the least costly treatment or what the outcome is. So we're talking about a system that pays and rewards value.

Now, why that is so critical is an example that I have from Houston with a neurosurgeon that I referred my patients to. When I couldn't handle their back or neck pain, I would refer my patients to this surgeon because I knew he was very conservative. He agreed with the philosophies that I have espoused. However, he was in the fee-for-service system. And so what happened is when there was an option not to operate, which he gets paid very well for and the hospital does, he would choose physical therapy or other less costly measures to see if those would work, and they often did.

When he needed to operate, he would operate. But then he came to my office one day and said, "David, I'm retiring."

And I was shocked, and I said, "Why?"

And he says, "I can't make it. My colleagues are in the operating room, operating all day, getting paid much more. I'm in the office, getting paid like a primary care doctor, and yet I have the same overhead, malpractice insurance and everything that other neurosurgeons have."

And so trying to do the right thing in the wrong business model actually drove this physician out of practice. And we can't have that.

Q. Dr. Pate, as part of your study, have you looked at what HMOs were doing in the 1980s and 1990s?

A. I have, because I often get the question, "What's the difference between the HMOs of the '80s and '90s and accountable care that we're talking about now?" And I emphasize that they're very different.

When the HMO movement -- unfortunately that was not provider driven, that was insurance company driven. And what I've said St. Luke's philosophy is, we've got to have our physicians driving this change. So that's one difference.

The other difference was the whole focus was just on reducing cost. And they were willing to do so for short-term gains; that is, try to deny or make access to more costly services just very difficult even if people needed it.

That's not what accountable care is. Accountable care is about delivering value. It's the quality and outcomes as well as how you can make the cost the most cost efficient.

Now, the other thing is we're much better prepared to do this today than back then. Physicians didn't have the

tools that we have today. We've got electronic health records -- and, sure, some of those have been around, but in their infancy, and they were not particularly effective; they're much more robust today -- so electronic health records to be able to share data, clinical decision support systems to be able to help physicians. There's just no way to keep up with all the evidence that's coming out. No matter how good you are, you cannot keep up with all of it.

And so by having clinical decision supports, where physicians are deciding what is the current best evidence and sharing that with everybody and having it embedded, now you equip the physician with the information he or she needs to make the right decision, and analytics to allow us to compare, how are we doing, are we making a difference.

So I think it's very different.

Q. So you've been with St. Luke's for a little more than four years now. Has St. Luke's succeeded in implementing the strategies that you've just outlined?

A. Well, I am very proud of what we've accomplished, but I also realize this is a journey, and we've got a long way to go. However, I think, as I think about just the things that we have accomplished in such a short time, I'm really amazed, and I'm confident that we will be successful in implementing our strategy.

I think of -- for example, you know, as I

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mentioned before, that the -- we thought reform was good, but not enough. We've got to transform healthcare. And, in fact, in my discussions with Dr. Don Berwick, the administrator for CMS, he said Washington can't fix these problems.

MR. GREENE: Objection, hearsay, Your Honor.

MR. BIERIG: I don't think it's being offered for the truth; it's just the witness is stating what has impacted him.

THE COURT: I'll sustain -- well, if it's being offered only for the effect upon the witness, whether true or not true, and the witness's decision making, so I'll overrule the objection, but with the understanding that it's not being offered for the truth of what was said by the person with whom Dr. Pate spoke.

Go ahead and proceed.

The objection is overruled.

THE WITNESS: And that providers are going to have to lead this effort. And so what we decided to do is to participate in the Medicare Shared Savings Program, a voluntary program that was made possible through the Affordable Care Act. And we became the first and only federally designated accountable care organization in Idaho.

So this past January we started our participation in the Medicare Shared Savings Program. I think when you look

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at what we've already accomplished with data analytics, through our partnership with White Cloud, and we've showed what we've got to some of these advanced systems like Intermountain Healthcare, and they don't have anything like this, and so now we've got -- we've already developed that.

And I think the physician leadership is critical. In fact, as I talk to my colleagues from around the country, that's the biggest problem that is challenging them, besides the business model, of how they're going to transform.

And so we've got all those ingredients, and because we've got all those things and with the progress we've made in such a short time, I've challenged my leadership team to have St. Luke's Health System ready to enter into value-based contracts for the majority of our business by 2015.

BY MR. BIERIG:

Q. Why has the transformation to a value-based contracting not been fully implemented at this time, in 2013?

A. First of all, you have to understand that what we're talking about is disruptive innovation. We're not talking about making tweaks to the current healthcare system. We're not talking about what has been referred to as sustaining innovations that just advances. We're talking about really transforming this whole model. This means you

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have to now think about healthcare in a completely different way. Whereas, today, in a fee-for-service model, I am always thrilled when my hospitals are full, in a pay for value, we will not want that. We've got to keep people out of hospitals.

So, you know, what the challenge is, first of all, to get my whole leadership team aligned, many of whom have spent decades working in the fee-for-service model. And they've got to -- you know, can you get your hands around this? You think in a new way.

Then getting the boards aligned, which we have tremendous board alignment across the health system.

And then you go and you have to have these physicians. And the problem is that when everything is working well for them they are not going to change unless they come to the same conclusion we did, that healthcare is unsustainable. And you've got to get them out of the mindset of that they're going to maximize revenue through all these investments and hospitals and ambulatory surgery centers, and imaging centers, and that kind of stuff, to be focused on what we're going to do is improve value.

The other part of it is that -- as I've said -- that is, the big challenge is aligning the business model. And we have -- and, you know, I understand, I am not faulting them, but the insurance companies have done

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extremely well under fee-for-service. They know how to manage that. And so they're a little bit resistant to completely change their model. And so without doing that, it just means you can't go as fast.

Q. So what has St. Luke's done with respect to Idaho's major insurance companies to try to promote healthcare transformation?

A. We have talked with all of the local payors. We have explained where we're trying to go, we've been seeking opportunities to partner with them. Would they help us? And I've explained to the insurance companies. We're not ready today to take risk. We don't have the balance sheet to do that, we can't take the total financial risk.

But I believe part of getting to the ultimate accountable care is providers have to be accountable for the outcomes and the cost of care. That means we're going to have to take financial risk. I've told them that we're getting geared up to do that; In fact, shared my goal that we need to be ready by 2015. So we have tried. Unfortunately they are very -- you know, we still don't have that relationship of partnering, and things are going very slow. And I have a real sense of urgency. I don't think we have the time to continue doing things like we are. We've got to change this. And I hear it from employers and people who can't afford healthcare all the time.

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Q. So apart from talking to the traditional Idaho insurance companies about transitioning to risk-based contracting, what has St. Luke's done with insurance companies?

A. Well, realizing we were not going to have our -- our strategy facilitated by local partners -- local payors, we've looked for a partner. And one of the obvious places for us to look was Intermountain Healthcare. They are recognized by our own industry as one of the leading health systems, they were recognized by President Obama as the leading health system, they've done great things, and they have a subsidiary insurance company called SelectHealth. And that company has been working with providers since the '80s at least, maybe before then.

And what we know is that they have a different philosophy about partnering with providers. So we've talked with them. We found tremendous alignment in vision and strategy. They were very excited about what we were doing, and so we have asked to partner with them.

Q. And when you say you've "asked to partner with them," what form has that partnership taken?

A. First of all, they are in the Idaho market, they are offering insurance plans, both on and off the insurance exchange, and our partnership is to now look at how they can help us prepare to take the risk, the financial risk, and

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that what will happen is instead of the traditional model, where the insurance company has the premiums and gives a smaller piece to the providers and keeps about 20 cents on the dollar for their profits, investments, and reserves, that SelectHealth agreed that they would only keep half of that. They run very lean; they would keep 10 percent for them, and we would have access to the 90 percent, which now gives us the financial model that allows us to invest in health and allows us to invest in making physicians whole so they are not penalized for not doing the expensive care and things when there is a less costly option that will get a good outcome.

THE COURT: Mr. Bierig, because of the problem I had yesterday, I have medication that requires I take just a very short break. So I'm going to take a five-minute break, if that's alright. And we'll still take a break in about an hour, like we normally would. So this will literally be five minutes. So if you need to leave the courtroom, make sure you are back in five minutes because we will start.

MR. BIERIG: I will stand right here, Your Honor.

THE COURT: We will be in recess for five minutes.

(Recess.)

THE COURT: I will remind Dr. Pate, you are still under oath.

Mr. Bierig, you may resume your examination.

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MR. BIERIG: Glad to see the court is practicing the first pillar, better health.

THE COURT: Well, I could have a discussion about that, but perhaps we shouldn't.

BY MR. BIERIG:

Q. Dr. Pate, what is your view on whether close financial and personal alignment with physicians is important in St. Luke's movement to value-based delivery of care?

A. Well, I think it's critical because, first of all, I base it on my own personal experience in Houston. I base it on my experience here in Boise and in Idaho. We have to align the incentives to get the things that the American people say they want, and that is better quality care at a lower cost. The incentives are not aligned that way now.

It's not surprising that the healthcare system is broken, because we're paying for things we say is not what we want. We've got to have a model that allows physicians to make the best possible decisions with the best evidence and to select those options that will get the best outcomes at the lowest cost.

Additionally, we've got to be able to give physicians the time and not be penalized, from a financial standpoint, because if you think about fee-for-service, which is what I practiced in, time was money. I had to keep

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my office clicking and patients going in order to make payroll and pay the expenses.

We need physicians to devote time to quality initiatives, to putting all this stuff together, the best practices, all that. And a great example that comes to my mind is Dr. Kevin Shea, S-H-E-A. Dr. Shea was on our medical staff for many years and then subsequently became an employee; he's an orthopedist. And he looked at our postoperative infection rates in people that have joints. And we were doing very well compared to the rest of the country, but try telling that to the patient who gets an artificial joint infection. You are talking about prolonged disability, prolonged time away from work and a cost that could be as much as a couple hundred thousand dollars additional. Healthcare did not have an answer for that, because we were already doing really well compared to the rest of the country.

Dr. Shea, because he had protected time, went to outside the healthcare industry. He went to Micron, to their engineers, because when they're making a chip or whatever the stuff is that they make, they can't have any contaminants in it, or it's defective. So they've figured out air systems and how to handle that. We went to Boise State University to get air engineers to work for us.

And we've been implementing those lessons from

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other industries in our ORs, and now our infection rate, which previously was very good, is half -- is already dropped in half. But we call it "project zero," because when I congratulated Dr. Shea, Dr. Shea said, "Don't congratulate me yet, we're only halfway there; we're going for zero." That's the kind of thing we can do with aligned physicians.

Q. Well, to what extent is your view on the importance of closely aligned physicians based on your study of other healthcare delivery systems?

A. Well, it is. As I have looked at others, I read the book that Mayo has put out about their successes, and they attribute it to Dr. William Mayo who said back in -- I think it was in the '20s -- he said he wanted physicians to be salaried so that they didn't have to worry about which patients they were seeing, they didn't have to cherry-pick, they didn't have to worry about how much time they spent with the patients, and they didn't have to be pressured to order tests.

THE COURT: Mr. Ettinger.

MR. ETTINGER: I think we're pretty far beyond the witness's experience, reciting what other people said in books.

THE COURT: I think the objection will have to be sustained on that. I think the witness can certainly

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testify as to his own belief, but if we're going to bring in other documents, we --

MR. BIERIG: I think the witness is explaining the basis for his belief. He's telling you how he formed his belief, what went into his experience that causes him to have these views. So it's hard to believe that he can't mention that he read a book that informed his view.

THE COURT: Well, I suppose similar to the last objection made, it is being offered only to show the impact upon Dr. Pate and his commitment to value-based healthcare.

I'll overrule the objection, but will not consider the, I guess, Dr. Mayo's statement for the truth, but only for the impact it had upon the witness in formulating his own view and opinion about the need for integrating clinical services into healthcare organizations.

Proceed.

MR. BIERIG: I'll ask a different question that perhaps will alleviate some of Mr. Ettinger's concern.

BY MR. BIERIG:

Q. To what extent have you looked at current systems in formulating your view about the importance of close personal and financial alignment?

A. Well, I've done several things: First of all, the Cleveland Clinic, Dr. Toby Cosgrove, who is the CEO of Cleveland Clinic, has been quite outspoken -- it's all over

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in documents and videos -- that he attributes the Cleveland Clinic's success to that salaried model.

Additionally, I've looked at the Pioneer Accountable Care Organization Pilot that just finished its first year. 32 organizations were in that, and there were 9 organizations that actually saved money for the Medicare program, enough that they could share in the savings. I looked at those 9 organizations, and what is common to them is all of them have at least a significant core of employed physicians, and most of them, in fact, had faculty practice plans where all the physicians were employed, and then wrapped around that independent physicians. Also when I looked at -- there were 2 organizations that were reported to have actually had increased costs, so they didn't get to share, and, in fact, it crossed the threshold that they had to refund money to the government. I couldn't find information publicly about both, but the one I did find was -- it was an affiliation of independent physician practices.

So based on everything that I've seen, what I've heard, what I've gone to other meetings, consultants, what seems to be the common theme in Kaufman Hall -- I mean, I'm not the only person that noted this -- they put out a publication where Ken Kaufman states it -- the common theme in the organizations that President Obama cited and the ones

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that I've just talked about is at least a core of employed physicians if not all of them employed.

Now, St. Luke's model is not to employ every physician, but all these policy leaders are agreeing it's at least a core of employed physicians.

Q. Let me move now to the Saltzer transaction. You're aware, are you not, Dr. Pate, that the focus of this litigation is the affiliation of the Saltzer Medical Group with St. Luke's?

A. I am.

Q. What has been your involvement in the Saltzer transaction?

A. Two things:

One, knowing the significance to St. Luke's, I have met, on several occasions, with the leaders and the executive committee to ensure that we have alignment on vision and strategy and to ensure that they understand what St. Luke's is trying to do and that I understand what their aspirations are, to make sure we're aligned.

The second thing was I was involved in the system board that gave final approval for the transaction.

Q. And when you say you were "involved," were you present when the system board discussed the Saltzer transaction?

A. I was.

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Q. In considering whether to enter into the relationship with Saltzer, what were the factors that the system board considered?

A. Well, first of all, the system board wanted representations from me that those physicians were aligned, at least the leadership. And then we had a short-term problem to address, and that short-term problem was that we were running out of capacity at our St. Luke's Meridian Medical Center. And the question that we are facing is were we going to do an addition to that facility. In looking at the patients coming to that facility, nearly 30 percent were coming from further west in the Treasure Valley. And so we considered should we add to the facility at Meridian or should we build a facility further out west in the Treasure Valley further.

And we concluded that it would be -- given that these patients were coming all this way and bypassing Saint Al's to come to St. Luke's, that we would be best served if we could build a facility in Nampa, and it would be less costly actually than adding on to the Meridian facility.

The longer-term problem was that -- back to what I talked about with community outreach, is the concept of population health management. This is a new concept, relatively speaking, in healthcare. And it's really the kinds of things I was talking about, about how do we manage

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the health of an entire population, some of which are patients, but many of which are not. How do you take accountability for managing that whole population?

And given that the population of Canyon County is growing, and given that we are a sought-after provider in those communities, the opportunity to have Saltzer Medical Group aligned and willing to help us provide population health management was a critical factor.

Q. To what extent did the board consider how the transaction would increase St. Luke's market share?

A. We didn't consider that at all. Our consideration was how was this going to advance accountable care and the Triple Aim.

Q. And how did you see that happening?

A. The biggest thing is, first of all, when you think about that Triple Aim, better health, better health of people who aren't patients and that it has no supporting business model, I think that's the most challenging piece to achieve. The alignment of Saltzer Medical Group and willing to commit to that Triple Aim and willing to help us with improving health in those communities, which they know best because they live and work in those communities, was tremendously impactful.

Better care is the -- the opportunity with the Saltzer Medical Group was to work with them to make more

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specialty services available to people locally and to coordinate that care better to get better outcomes at lower costs.

Q. What role, if any, did the desire to increase price to commercial payors play in the board's decision to approve the affiliation with Saltzer?

A. None whatsoever.

Q. To what extent did a desire to implement the Triple Aim in Canyon County influence the board's decision to approve the affiliation with Saltzer?

A. It was virtually the total basis for approving that.

Q. Did the board of the St. Luke's system consider the competitive effects of the Saltzer affiliation?

A. You know, the board's approach to this is, first and foremost, what's in the best interest of the community. Second, what will help advance our vision and our strategy and serve the people better. And third, will this be procompetitive, which we saw it, from our view, as extremely procompetitive, especially given that the Saint Al's Nampa hospital was the only hospital choice there.

And we had created a small urgent care/emergent care center in Nampa, and what we saw was an amazing turnout of people supporting it and thanking us for giving them choice. And so we thought this was going to be very, very

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procompetitive.

Q. Did the board consider a request by the State of Idaho not to close the Saltzer transaction until the State had completed its investigation?

A. Yes. We considered that very seriously and very carefully. There were several factors that prompted us to move ahead. First of all, we had made an agreement with Saltzer that we would close by the end of the year, so we had that commitment. That wasn't overriding.

Second is that by the time of the board's decision, Saint Alphonsus had hired away the seven highest revenue-producing surgeons for the Saltzer Medical Group, and we were aware that that was going to have a tremendous financial hardship on the medical group because those seven physicians accounted for $2 million worth of additional overhead. So we knew that the physician group was going to be strapped, and, in fact, we believed that their very survival was going to be threatened.

Saltzer was very important to us in being able to carry out our vision in the western Treasure Valley. It was critical to our ability to offer a new product out to those people. It was something that we felt was very important and very important for the community. It was very important to Saltzer. Saltzer had decided, after considering both St. Al's and St. Luke's, that they were most aligned with

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St. Luke's.

And then, frankly, looking at the course of the investigation, from the time the investigation started to the time we even just got our first subpoena was seven months. And I thought -- and we turned over I don't know how many -- voluminous amounts of documents. So I had no idea. And the government was not telling us a date certain that they would finish their investigation. We thought this could go on for years and, in fact, the survival of Saltzer would be threatened and all of this would become moot, and it would hurt the community.

MR. GREENE: Your Honor, objection. We move to strike the discussion of the alleged weakness -- financial weaknesses of Saltzer. There has been no foundation laid for that answer.

THE COURT: Mr. Bierig.

MR. BIERIG: Your Honor, the question was did the board consider the letter from the State of Idaho, and why did it act as it did.

THE COURT: Well, I think it gets to be a bit nonresponsive. Let's get the question back before the witness.

Let's go ahead and proceed.

BY MR. BIERIG:

Q. Well, the question was: Why did the board

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determine to go forward? What were the factors -- let me rephrase it.

What were the factors that the board considered in making its decision to go forward with the Saltzer transaction in the face of a request by the State of Idaho that it hold off on the transaction?

THE COURT: Just so we're clear, I think the concern from Mr. Greene was that we were having the witness testify about the financial circumstances of the Saltzer Medical Group without a foundation for the witness's understanding of that. I suspect, again, the witness is only testifying about what his understanding was and the motivation. And I think motivation for the merger is in fact an issue in the case. So on further reflection, I'm going to overrule the objection and allow the answer to stand.

I see, Mr. Bierig, as you were struggling to rephrase the question, I put you in an untenable position, because it probably was a properly phrased question and a proper answer. So I'll overrule the objection.

MR. BIERIG: Thank you, Your Honor.

THE COURT: Go ahead and proceed.

MR. BIERIG: In that case, I'll move on because I think the witness has answered.

BY MR. BIERIG:

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Q. Dr. Pate, did the board consider whether St. Luke's could achieve the Triple Aim in Canyon County through a looser affiliation with Saltzer?

A. It did not. I didn't bring that option to the board because, first of all, I wouldn't take a recommendation to the board that I couldn't support. My own experience in Houston taught me it wouldn't work. It was inconsistent with what we were trying to achieve, and in fact, Saltzer had asked us for the tighter affiliation. So a looser affiliation was really not on the table.

Q. And when you say you couldn't recommend a looser affiliation, what was the basis for that belief on your part?

A. Because in my discussions with the Saltzer leadership, they wanted -- they shared our vision and our strategy. They realized that the only way that could succeed was to get away from the total fee-for-service drivers of this and that we had to work together. And they were willing to do so and willing to commit to that. And so given the importance of us achieving our vision and the strategy and being able to offer a new product in this market, we felt like it only made sense to go forward in the manner that Saltzer had requested.

Q. Now, plaintiffs in this case allege that St. Luke's will use the Saltzer transaction to drive up

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prices for healthcare services. As president and CEO of St. Luke's, what is your reaction to that allegation?

A. Well, I think that given that, as I said before, we are Idaho's only locally owned, locally governed health system. Our board of directors are all people who are part of this community and have been part of this community for a long time. They are well connected in this. They want us to fix what's wrong with healthcare. Our board of directors wouldn't stand for this.

Further, our board of directors, a lot of them, run businesses in these areas that would be impacted if we tried to charge excessive or unreasonable prices. And even if their business wasn't impacted, they are so closely networked in the community that they would hear from others that they know. And believe me, that board would be coming back to me and feeling that this was unacceptable from management.

Q. Prices are determined by St. Luke's management rather than the board; is that not correct?

A. That is correct.

Q. So how can you be confident, given that management sets price, that prices will not be set above competitive levels?

A. Well, I think it's back to my previous answer. Our board members are -- a lot of them are business owners;

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they run businesses here. They would be negatively impacted, and they would let us know about it. In fact, I hear about the challenges they have. And they're very excited that we're designing a program to address these issues. But they're so -- I mean, this is a very small community, relatively speaking.

I mean, the entire state of Idaho is less population than I had back in Houston in that city. So you hear about these things, and they would know if we made any effort to charge unreasonable or excessive prices, and they just wouldn't tolerate it. And I can guarantee you I'd hear from the board.

Q. What constraints, if any, apart from the board's view, are there on the ability of St. Luke's to raise prices above competitive levels?

A. Well, there is tremendous restraints here. This market, unlike the market that I came from in Texas, has an unbelievable dominant payor in the market. And Blue Cross is so dominant that they are a must-have for us. We couldn't just walk away from their business. And even Regence, we have been in negotiations with them for the last year on a contract asking for a change. After a year we just gave in. We couldn't even get anything that we asked. But this is a process of negotiation, and the -- we just can't get what we want.

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And then there is two other things.

THE COURT: Which you'll get to in a moment.

THE WITNESS: Yes.

THE COURT: Mr. Ettinger.

MR. ETTINGER: Your Honor, I'd like to object on foundation grounds. Dr. Pate is certainly the CEO of the system. I believe, based on the record, that he's had virtually no involvement in managed care negotiations, and he doesn't even talk to some of the people directly involved very much. And so I think a foundation ought to be laid before he offers opinions as to the impact of various managed care payors and what their negotiations have been. Like many CEOs, you know, he has a lot of people below him who do a lot of these things.

THE COURT: I'm going to overrule the objection and allow the witness to testify. Again, since Dr. Pate is obviously a driving force behind this decision, his motivation and his reasoning for it, whether his assumptions are correct or incorrect. I'm not going to consider his testimony for the accuracy of whether or not Regence or Blue Cross were or were not in active negotiations with St. Luke's or vice versa, but only that this witness has testified that was his understanding in forming his conclusions as to the way forward for St. Luke's.

But counsel will just have to trust me that I'm not

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concerned for the truth of that. Other witnesses can testify to that. And if they don't, then I'll assume there is no basis for it other than just Dr. Pate's assumptions.

So go ahead, Mr. Bierig.

MR. BIERIG: Thank you, Your Honor. Well, the witness said that he had two other reasons, so I would like to ask him what the two other reasons are.

THE COURT: I assume we're now going to tick off items two and three. So go ahead.

MR. BIERIG: That's my assumption, as well. I'm looking forward to hearing what they are.

THE WITNESS: Thank you, Your Honor.

Well the two other things, one was, I mean, I think St. Luke's learned from the loss of the Micron business that we have to be able to compete on price or we're going to be subject to loss of business. That hurt us.

And then, finally, something that happened shortly after I got here, I got contacted by an employer in Wood River who told me that -- this was prior to alignment of our prices there, so they were a little out of whack in Wood River -- and he told me that they were sending employees to Salt Lake City for services because prices for some our imaging and procedures were too high, so we reduced our prices. We are subject to pressures from even relatively small- or medium-sized employers.

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BY MR. BIERIG:

Q. Dr. Pate, the hospital plaintiffs in this case have alleged that the Saltzer transaction will cripple them competitively by drying up referrals. As the president and CEO of St. Luke's, what is your response to that allegation?

A. Well, I feel that there is no basis for that. One of the things that has -- was clear to me when I got here is that St. Luke's never had a practice of directing patients. That's up to physicians. And even if that weren't the practice, as a physician, I would find it completely objectionable for us to direct where our physicians are supposed to refer business.

For heaven's sakes, I took my wife to a St. Luke's physician, and that physician referred my wife to a Saint Al's physician, so I know that they're not directing them all within St. Luke's. So I wouldn't tolerate it. I would find it highly objectionable.

I knew from the discussions that I had with Saltzer leadership that this was a very important issue to them, that they be free to refer wherever they want to. And I immediately said, of course. I couldn't imagine anything else. They should. And, in fact, their specific concern was the ability to refer to the Saint Al's Nampa hospital, and I told them that I couldn't imagine not using the only hospital that's there in Nampa. And I knew that Saltzer

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cared for many Saint Al's employees. I mean of course, they're going to want their care at that hospital, and I don't think we would have had the capacity to take their business even if we wanted to direct it.

So no, we do not direct referrals, and as long as I am CEO we will not direct referrals.

Q. What is your view on the strength of Saint Alphonsus as a competitor of St. Luke's?

A. Well, my view is, and has always been since I got here, that Saint Alphonsus is a very strong competitor. And I like that because, frankly, they push us to be better and I think we push them to be better. So I think that's a very good thing. You know, in Houston, my next two competitors, one of them was closer than the parking lot here to this courthouse. I am used to having competition, and it only drove us to be better, so that's a good thing.

Second, more recently, you know, they're part of the Trinity system. Through the mergers and acquisitions of Trinity, they are now the third largest nonprofit health system in this country. And to put that in perspective, they are about ten times bigger than the size of St. Luke's. So I just, I see them as a very strong competitor.

Q. Has Saint Alphonsus done or said anything that confirms your belief in the strength of their competitive position?

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A. Oh, absolutely. I was, frankly, amazed that after I heard about the allegations that they were somehow going to -- their very existence was going to be threatened by our transaction with Saltzer, and after Saltzer had already made the decision to come with St. Luke's, I read in the *Statesman* and received at my home a brochure stating that Saint Alphonsus was investing $33 and a half million in the Nampa area to expand their hospital services. And, to me, I mean, I just don't think they even believe what they're saying.

A competent healthcare leader would not make the decision to put $33 and a half million at risk if they sincerely believed they were going out of business there. And I think that would be a flagrant foundation of the fiduciary responsibilities of the Saint Alphonsus board if they believed that they were going to be threatened to spend that kind of money that should be going to the community.

Q. You say "a flagrant foundation." Did you --

A. Sorry. A flagrant violation of their fiduciary responsibility.

Q. I am going to ask the Court to put up Defendants' Exhibit 2640, if you wouldn't mind.

MR. ETTINGER: Your Honor, this is something we just received the other day. We don't have an objection as long as this is -- as long as Mr. Bierig is using the entire

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document. What he provided us was three cherry-picked pages.

THE COURT: I assume you're going to offer the entire document, Mr. Bierig?

MR. BIERIG: I can easily offer the entire document. I'm only going to inquire about one page. I have given Mr. Ettinger the entire document so he will be free to cross-examine.

THE COURT: Mr. Ettinger, I assume that is satisfactory?

MR. ETTINGER: Yes, Your Honor.

THE COURT: Now, Mr. Greene -- we've got two attorneys objecting. I'm assuming both of you may cross-examine.

MR. GREENE: Yes, Your Honor. I'll go first and then Mr. Ettinger.

THE COURT: Do you have any objection to 2640?

MR. GREENE: No objection.

THE COURT: All right. 2640 will be admitted.

(Defendants' Exhibit No. 2640 admitted.)

BY MR. BIERIG:

Q. Can you identify for the record the date of this document?

A. It says winter -- winter of 2012.

Q. And so that would be the November, December of

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2012?

A. I don't remember which month I received it, but I remember this was in my mailbox, and I remember looking at the article I'm sure you are going to and thinking they know that Saltzer has chosen to come with St. Luke's; why are they investing this 33 and a half million if they really believe that they're going to be devastated by this.

MR. BIERIG: Well, I would ask the court to put up page 2 of the exhibit as it currently stands.

BY MR. BIERIG:

Q. You'll see a picture of a hospital there, or what appears to be a hospital?

A. I do.

Q. Could you read the line that is underneath the picture of the hospital?

A. It says a $33.5 million expansion of services, quality, access to care."

Q. And what did you understand that sentence to mean?

A. That Saint Alphonsus Health System was devoting $33 and a half million to expand their current hospital services in the Nampa market.

Q. Is it your testimony that that statement was published after Saint Alphonsus knew about the affiliation between Saltzer and St. Luke's?

A. It was.

Q. Dr. Pate, what is your view on the strengths of Treasure Valley Hospital as a competitor?

A. Well, the advantage that Treasure Valley Hospital has is quite the opposite of what I was talking about earlier; they have a perfectly aligned financial model which incentivizes the physicians to use that facility and to do these high-revenue services. So I think they have a very strong business model. And as long as it continues to be legal for physicians to self-refer, I think they are in great shape.

Q. I just have one small series of questions, Dr. Pate. You wrote an article that has been referred to previously in this case in the *Journal of Legal Medicine* entitled, "Hospital-Physician Relations in a Post-Health Care Reform Environment"; is that correct?

A. That is correct.

Q. When was that article published?

A. That was published in the beginning of 2012, is my recollection.

Q. I'm going to quote a statement that you made in the article. Specifically you stated as follows, quote: When a specialist experiences a number of his or her referring physicians being hired by a hospital, this creates pressure for the specialist to consider employment with the hospital to preserve the referral base, end of quote.

Do you recall making that statement?

A. I do.

Q. Does that statement continue to reflect your views?

A. It does, but it's very important to understand what that statement says. What it says, that it does create pressure for them to consider. Now, I will tell you, in my experience, I have never actually had that happen, where a specialist sought employment from us because of the referral sources being employed by us. Frankly, most of these physicians have diverse sources of referrals, and so that doesn't tip it.

And, in fact, as I testified before, we don't direct referrals, and so we find that it is quite typical for our physicians to continue to refer to those physicians.

And, finally, I would say the Saltzer Medical Group is a glaring example of how it is only consider, but they in fact decided not to go with the organization where the primary care physicians were going.

Q. And where did they go?

A. They were employed by Saint Alphonsus Medical Group.

Q. I have no further questions, Your Honor.

THE COURT: Mr. Ettinger, you're going first or Mr. Greene?

MR. GREENE: I'm going first, Your Honor. Thank you.

THE COURT: You just told me, and I'd forgotten already.

MR. BIERIG: This Exhibit 2640 has been admitted, Your Honor?

THE COURT: Yes, it has.

MR. BIERIG: Thank you.

MR. ETTINGER: Your Honor, I assume that's the entire document, not the --

THE COURT: No. The entire document will be admitted.

MR. BIERIG: I will provide -- actually my only -- Mr. Ettinger has my only copy.

THE COURT: Now, I'm assuming we're only talking about the article in question, not the -- apparently it was a magazine of some type or a publication.

MR. BIERIG: A publication that Saint Alphonsus distributed to the population in this area.

MR. ETTINGER: It's an eight-page brochure.

THE COURT: The entire document is admitted.

MR. GREENE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. GREENE:

Q. Good morning, Dr. Pate.

A. Good morning.

Q. Now, Dr. Pate, St. Luke's expects to achieve clinical integration with independent physicians; correct?

A. That is correct.

Q. And specifically, St. Luke's Select Network will make a number of clinically integrated independent physicians as part of the network; correct?

A. Yes. But I'm not sure you said the name right. Did you say, "Select Medical Network"?

Q. I did.

A. Okay, good. Yes, that's correct.

Q. And you have discussed this on your blog, as I understand it; correct?

A. Yes.

MR. GREENE: Mr. Oxford, if you'd bring up cross Exhibit 3004, please. And if you would highlight the first two paragraphs when you get the opportunity. Your Honor, just a side note while we're doing this. I will need to close the courtroom in a few minutes just because we're going to switch to AEO here?

THE COURT: At this point?

MR. GREENE: No, no. This is public. I'm going to try and do two publics.

THE COURT: We'll take a break about 20 minutes after. I don't know if that will help you in your timing.

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But if not, we'll just clear the courtroom.
MR. GREENE: Much of my cross will actually involve AEO.
THE COURT: All right.
BY MR. GREENE:
Q. Now, Doctor, let me read this portion of your blog: "One of St. Luke's strengths is in recognizing the value of partnerships and being able to work collaboratively to solve very challenging problems in healthcare. We recognize the importance of working with aligned physicians and other providers, whether employed or independent. We know that we are not in a position to manage the total care of a population in a way that can be accountable for when it comes to outcomes and costs. The delivery system necessary to provide this population health management will include St. Luke's, but includes many independent physicians and facilities all working together around the state. The delivery system for our area of the state that St. Luke's belongs to is Select Medical Network, and the statewide delivery system of which Select Medical Network is a part is BrightPath."
Did I read that correctly, sir?
A. Yes, sir.
Q. And that reflects your views, then?
A. It does.

1659

Q. And it currently reflects your views?
A. It does.
MR. GREENE: Now, Mr. Oxford, could you bring up Plaintiffs' Exhibit 1658.
Your Honor, this is a memorandum from Dr. Pate. It has been admitted by stipulation and is not AEO.
THE COURT: Yes.
MR. GREENE: Mr. Oxford, could you bring up the third paragraph so that we could see it a bit more clearly?
BY MR. GREENE:
Q. And let me just read this to you, as well: "In order to prepare our organization to take not only the accountability for clinical outcomes, but also for the cost of that care, we must add aligned independent physicians to the core physician group we have within the St. Luke's clinic. By developing relationships with independent physicians who are willing to participate in evidence-based medicine, agree to share quality data, and agree to hold themselves accountable for the performance of the network, we increase our ability to provide clinically integrated accountable care to the patients we all serve. We have already established this network of St. Luke's clinic physicians and independent physicians, and it is called Select Medical Network."
Did I read that correctly, sir?

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A. You did.
Q. And the fourth paragraph, if you could highlight that, Mr. Oxford.
And you are indicating here, let me just read: "Select Medical Network is critical to the success of our transformation of healthcare. For this reason, I have asked John Kee, VP physician services, to transition to a new role as Vice President, Network Operations."
Then continues with, "This move will allow John to focus on fostering strong physician relationships and supporting the alignment and clinical integration efforts with independent physicians across the system. Further development of the network will position us well for the future of population health management and accountable care."
Did I read this portion of your memo correctly?
A. You did.
MR. GREENE: Now, this is the point where I have an AEO document, Your Honor, and I apologize to our --
THE COURT: Ladies and gentlemen, we will have to clear the courtroom while the witness is being examined concerning this document.
Are there any parties who can remain in the courtroom, Mr. Greene?
MR. GREENE: This is a St. Luke's document. I

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leave it to my --
THE COURT: All right. So the St. Luke's employees can remain in the courtroom?
THE WITNESS: Our board chairman could remain, couldn't he?
MR. BEIRIG: Yeah.
MR. SINCLAIR: Mr. Saldin.
MR. GREENE: I think we're set, Your Honor.
******COURTROOM CLOSED TO THE PUBLIC******
MR. GREENE: Mr. Oxford, could you bring up Plaintiffs' Exhibit 1510 -- which has been admitted by stipulation, Your Honor.
BY MR. GREENE:
Q. You can certainly take a look at this when it comes up, Dr. Pate. This is Exhibit 1510. It's an email chain between you and Mr. Fletcher dated October 6, 2012.
Mr. Fletcher is your chief operating officer for St. Luke's Health System; isn't that correct?
A. That is correct.
Q. Turning to the third paragraph, four lines down, of your portion of this email string, it reads, "Select Medical Network will be responsible and accountable to me. The purpose of SMN is to involve sufficient numbers of independent physicians with our St. Luke's clinic through clinical integration to permit our successful management of

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populations of patients throughout our health system's geographic area (and through BrightPath for members requiring care outside of our geographic service area, but within the state)."

Did I read correctly, sir?

A. There was a slight minor but not substantive -- yes, it's basically correct.

Q. Thank you, Doctor.

Mr. Oxford, could you bring up Plaintiffs' Exhibit 1212.

Now, Dr. Pate, this is one of your blog entries. And your blog, as I understand it, is called Dr. Pate's prescription for change; that is correct?

A. It is. Except I can't read it. I'm not sure if it's my entry or a guest blogger, but it is my blog.

Q. We can pop the text. I can also give you a binder with the actual document and paper if that would be helpful.

A. I can actually tell now. This was a -- it wasn't written by me, it's a guest blog, but, yes, it's my blog.

Q. And many of the blog posts you write yourself; is that correct?

A. The majority.

MR. STEIN: Could you give a binder to the witness?

MR. GREENE: We haven't yet. My apologies. The

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small version.

THE COURT: That hanging cord is making me nervous. I'm assuming --

MR. POWERS: It will catch anybody that goes this way, Your Honor.

THE COURT: That's very reassuring.

All right. I assume we'll just be very careful and perhaps try to unplug it on breaks or something.

Go ahead, Mr. Greene.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

Q. Dr. Pate, many of these blog posts you write yourself; is that correct?

A. That is correct.

Q. And occasionally you ask others to do sort of guest articles for you; is that correct?

A. That's correct.

Q. And in this particular instance you asked Mr. Billings to do a guest appearance on your blog; is that correct?

A. I did.

Q. Your intro, as I read this, is, quote, I've asked Randy Billings, St. Luke's Health System vice president of payor and provider relations, to share his perspective on the difference clinical integration can make, closed quote.

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Did I read that correctly?

A. You did. And those would be my words, that --

Q. Right.

A. Yes, correct.

Q. And I was going to ask you.

So the rest of this is Mr. Billings with your obvious sponsorship. And let me see if I understand what he writes. Mr. Billings explains that prior to coming to St. Luke's he led contracting efforts for advocate health care; correct?

A. I don't see that here, but I know that to be the truth, yes.

Q. Let me turn to the second to the last paragraph, where Mr. Billings writes: "The Triple Aim will be realized only within and dependent upon such a clinically integrated network. And while the financial incentives of participating providers must be aligned, a clinically integrated network is not necessarily a network of providers under common financial ownership. The Patient Protection and Affordable Act allows government-approved accountable care organizations, ACOs, that can consist of otherwise financially independent provider competitors that are clinically integrated."

And then on the next page he continues --

THE COURT: Could you leave it there just for a moment before you switch. I want to finish reading that.

1665

Although you were reading it, I wanted to look at it again.

Go ahead.

BY MR. GREENE:

Q. Continuing on to the next page, Mr. Oxford, if you would switch us. The last partial bit of text: "Clinical integration with independent providers is clearly the essential building block of accountable care."

Did I read that correctly?

A. You did.

Q. Now, Dr. Pate, it is possible to design incentives that improve quality without employment; isn't that correct?

A. Yes, sir.

Q. And, in fact, you told me this in an investigational hearing, I believe.

Mr. Oxford, would you bring up page 156 of Dr. Pate's investigational hearing?

THE COURT: Counsel, is this marked as an exhibit?

MR. GREENE: It is marked as -- excuse me, Your Honor -- it's marked as Plaintiffs' Exhibit 3006. And this was -- as part of our investigative process we do essentially depositions before filing, so this was an investigative deposition transcript.

BY MR. GREENE:

Q. And do you recall this process?

A. The process of my investigational hearing?

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Q. Yes.
A. **Yes, I do.**
MR. STEIN: Your Honor, I'm not sure what counsel is driving at. The witness has already agreed with the previous statement asked by Mr. Greene, so I don't know what he's seeking to impeach here because the witness has already agreed with the statement.
MR. GREENE: Well, Your Honor, I think, certainly -- I believe my colleague is referring to Federal Rules of Evidence 801(d)(1), which relates to statements that may be contrary to prior statements. 801(d)(2) speaks specifically in terms of statements by a party opponent, and it comes in that way.
THE COURT: I was going to equate that to a deposition of -- obviously a deposition of a party, although here you'd probably need a 30(b)(6) designee. But more importantly, I think counsel is correct; it is a statement by a party opponent or its representative and, therefore, nonhearsay.
MR. GREENE: Thank you, Your Honor.
THE COURT: So I will overrule the objection.
My primary concern now is I'm having a hard time identifying for the record. This has been marked?
MR. GREENE: Yes, it has been marked as Plaintiffs' Exhibit 3006.

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THE COURT: And is that the plaintiffs' demonstratives?
MR. GREENE: That's in the demonstrative series, Your Honor. I mean, it is obviously evidence, but we -- there was no obvious place to put this.
THE COURT: You're not offering the entire transcript, only that portion which you just read?
MR. GREENE: Just the portion I'm reading.
THE COURT: All right. Proceed.
MR. GREENE: Okay. Thank you.
BY MR. GREENE:
Q. And you recall, Dr. Pate, you were under oath?
A. **That's correct.**
Q. And you promised to tell the truth; correct?
A. **I did.**
Q. And the question I posed to you and your answer: My question was, "Accountable care requires a different business model to support it. Instead of fee-for-service, it may be promoted through episode-based payments. Now, based on this are you suggesting that an employment relationship is not necessarily the only way to provide the incentives to for the integration of care."
And you answered, "I think it is possible to design incentives with quality and, in fact, I think -- without employment, and I think that's why we were so successful in

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Houston."
Did I read that correctly, sir?
A. **You did.**
Q. And Mr. --
MR. BIERIG: Your Honor, I would ask that if --
THE COURT: I was waiting. Yes, I'm going to direct counsel to read the entire response under the doctrine of completeness.
I assume that's what -- Mr. Bierig, I may have anticipated too much.
MR. GREENE: If I can have the rest of that transcript. I don't have it in my notes, Your Honor.
THE COURT: Well, the problem is that the answer is broken up into at least two pieces. And I think what -- Mr. Bierig, you're asking that the entire response be read into the record?
MR. BIERIG: I am. But I'm also asking that the entire question be shown, because the question that I see is, "Uh-huh."
MR. GREENE: Your Honor, if we may -- if we may move on, because they're finding it for me, and I will certainly --
THE COURT: If you'll come back, and let's read the entire question.
MR. GREENE: Of course.

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THE COURT: I think that's what I meant, Mr. Bierig, it was broken up by an affirmation by, I think, Mr. Greene during the questioning. So we will read the entire question and both pieces of the answer that were separated by the aforementioned comment.
MR. BIERIG: Thank you, Your Honor.
MR. GREENE: And, Your Honor, I would like to --
BY MR. GREENE:
Q. Now, Dr. Pate, conversely, employment doesn't guarantee alignment, correct?
A. **That's correct.**
Q. And I believe you responded to my question with respect to this in your deposition or responded to a question at your deposition.
Mr. Oxford, can you bring up pages 1029 to 1035 of Dr. Pate's deposition transcript. And if you can play that tape, that would be terrific.
(Video clip played as follows:)
Q. "What you were talking about earlier when you say that, you know, even within your population of employed physicians, you're not sure that everybody is aligned with the vision?
A. "Yeah. I think that we have great alignment, but I don't think that there is 100 percent alignment. And my point being that

employment by itself doesn't guarantee alignment. You have to work at these relationships to create alignment. And so that was the point of that."

(Video clip concluded.)

BY MR. GREENE:

Q. Thank you. Doctor, I do have the complete transcript before me, but I don't have an obvious way to show it to you. If I read it to you, would that be sufficient? Did you have -- I do have it actually.

THE COURT: All right. Let's switch over to the ELMO, and we can --

Face up is probably a good start. And maybe that's where we -- there we go.

MR. BIERIG: I would just ask, Your Honor, as this is going forward that the witness be given an opportunity to see the entire context of the question before he's asked to respond.

THE COURT: Let's -- Mr. Greene, if you'll ask the entire question and then read in the witness's response.

MR. GREENE: Of course, Your Honor.

BY MR. GREENE:

Q. This is the --

THE COURT: It probably would start on -- looks like page -- is it 155, line 7?

MR. GREENE: Yes, it starts at 155, line 15.

THE COURT: I'm suggesting line 7 because -- to put it into context, there's a reference to page 13 in your question.

BY MR. GREENE:

Q. "Okay. I have placed before you an exhibit, which is from the *Journal of Legal Medicine*, which you authored, and it's called, quote, 'Hospital-Physician Relations in a Post-Health Care Reform Environment,' dated March of 2012.

"I presume you're intimately aware of what's in this document?

A. "Very familiar.

"Okay. I'm just kind of interested in this whole" --

THE COURT: Just a second. The "Okay" is we start with a new question?

MR. GREENE: Yes. The new question starts after he says, "Okay."

BY MR. GREENE:

Q. New Question: "Okay. Now, I'm just kind of interested in this whole, you know, employment versus other kinds of structures. So on page 13, you're talking about accountable care, and let me just read a portion of this. Towards the bottom, it's the -- basically the second from the bottom paragraph reads, quote, 'Accountable care

requires a different business model to support it. Instead of fee-for-service, it may be promoted through episode-based payments, shared savings, pay for performance, value-based purchasing'" --

THE COURT: Could you slide up so we can see. There. Thank you.

BY MR. GREENE:

Q. -- "'partial capitation, global capitation, or various other models that provide aligned incentives to providers for providing value in healthcare services, as opposed to payments for each service provided. The business model for accountable care may vary and will certainly evolve with time.'

"Now, based on this, are you suggesting that an employment relationship is not necessarily the only way to provide incentives to -- for the integration of care?

A. "It depends, it depends. It would limit certain types of incentives, but it doesn't preclude all kinds of incentives.

"So in other words, there are many things that need to be aligned, and I mentioned two things in -- I think it was in the provider -- the PSA agreement that you showed me, that incentives were along two lines, quality and lowering cost.

Q. "Uh-huh.

A. "I think it is possible to design incentives with quality and, in fact, I think without employment, and I think that's why we were so successful in Houston. I mentioned what we had done with improving quality there. I think you can do that.

"We did not, in Houston, lower the total cost of care, I am confident. I don't know what it was, but I am confident that we didn't lower it. I think because there was just very little alignment from a financial standpoint. Without the financial alignment you are limited to what incentives you can provide. Many of those incentives would be illegal.

"So back to the example where I am saying, you know, I want to improve diabetes care that you -- you could do. I think you could actually do that, and that's not really going to come out of somebody's pocket. But if I wanted to try to reduce spine surgery, I'm going to hit a brick wall, because the way that you lower those costs, it comes out of the surgeon's pocket, and they are just not typically going to act against their own economic self-interest to do that."

That's the end of his answer.

THE COURT: Thank you, Mr. Greene.

MR. GREENE: Thank you, Your Honor.

BY MR. GREENE:

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Q. Now, Dr. Pate, it's also the case that you would expect some version of clinical alignment with Saltzer even if the deal is unwound; isn't that correct?

A. Well, I don't know what the judge's orders would entail if this had to be divested, so I don't know what we would and would not be able to do. But I can tell you that we would want to work with Saltzer Medical Group, or whatever part of it survives, even if it had to be divested, as long as it was consistent with the judge's order.

Q. And you would be willing to consider a joint venture with Saltzer; correct?

A. I would consider that. Again, subject to the judge's orders.

Q. Sure. And I believe you told us that, or at least a version of this, in your deposition.

Mr. Oxford, would you play from Dr. Pate's deposition 1676 through 1681.

(Video clip played as follows:)

Q. "You see in your email to Ms. O'Keefe on May 10 at 11:27 a.m., you say, 'My guess, just between you and me, is that we do not proceed with Saltzer in current scenario but look to other ways to partner, work with the group'?

A. "Yes.

Q. "And who is Ms. O'Keefe?

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A. "She is my system leader for human resources.

Q. "What other ways would you -- would you partner or work with Saltzer if the current transaction had not proceeded?

A. "Um, we were willing to consider joint ventures or, actually, whatever they would be willing to. We really hadn't spent any time discussing it because we'd been looking at the current model, but certainly we want to work with physicians that want to work with us however we can. So it was meant to be very" --

(Video clip concluded.)

THE COURT: Counsel, it just struck me, I think we've not -- everyone in the courtroom is still just St. Luke's employees or affiliated with St. Luke's.

MR. GREENE: That's my understanding.

THE COURT: Are you still involved in AEO?

MR. GREENE: This I believe has been designated as AEO.

THE COURT: Okay. All right. We're going to take the break anytime in the next five minutes, so you can pick your spot, Mr. Greene.

MR. GREENE: Okay. Thank you, Your Honor.

BY MR. GREENE:

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Q. Now, you mentioned in your conversation with my colleague Jack Bierig that at the system board, or as I understood what you told me, that the board did not consider the costs and revenues associated with the transaction. Is that a correct understanding of your testimony?

A. No, that's not correct.

Q. So they did, in fact, consider the revenue stream and the costs associated with this agreement?

A. Yes. They fulfilled their fiduciary responsibilities with respect to that.

Q. And as I understood your testimony, you indicated that you did not tee up or provide to the board a looser alignment option, it was only the employment option; is that correct?

A. That's correct.

Q. Now, the system board was not the only board to consider this transaction; isn't that correct?

A. That's correct. The system board was the final decisionmaker because this exceeded the thresholds authority delegated to the Treasure Valley board, who had the primary responsibility.

Q. So it's the case that the Treasure Valley board also reviewed and approved this transaction; is that correct?

A. That's what we were told. I was not in attendance

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there, and I certainly would believe that that would be the case.

Q. Did you get reports on that meeting?

A. I did not.

Q. You did not.

A. It wasn't presented as part of our system board presentation that I can recall, other than this came up on recommendation of the Treasure Valley board.

Q. And you presumably, then, have no knowledge of whether that board was at all concerned about the potential dominance that might result from this transaction?

A. I would find that very surprising, but, no, I have no direct knowledge.

Q. You have no knowledge one way or the other?

A. No knowledge.

Q. And you've not had the opportunity to speak to Director Jim Everett about his concerns and the concerns of some of the other board members with respect to dominance in market share?

A. I have not heard any concerns from him. I've certainly had opportunities to talk to him, but I've never heard if --

Q. So you have no knowledge one way --

A. No.

Q. -- is what you're telling me?

A. Correct.
Q. Generally, the board relies or the system board relies on your good judgment, as I understand it, when they make their decisions; is that correct, Doctor?
A. Well, they certainly count on my good judgment. And I don't think that's the whole basis for their decisions. I don't mean to suggest that. But I do think they rely on me to give them good advice and to present issues to them.
Q. And occasionally when you give that advice you would rely, at least in part, on your law degree, I presume?
A. Well, occasionally, yeah.
Q. And you've spoken on this litigation on your blog; correct?
A. I have.
Q. And you've spoken publicly otherwise on this litigation; correct?
A. I'm trying to remember. You mean in some particular public thing? Like, I have talked to the newspapers; they've interviewed me and so forth. Is that what you mean?
Q. Yes. I'm thinking specifically, Doctor, about your presentation to the "young lawyers section" of the Idaho State Bar, in May of this year, concerning healthcare and the law.

A. Yes. I talked to some law students.
Q. And do you recall answering a question about whether it was helpful to be both a doctor and a lawyer in managing the processes at St. Luke's?
A. I don't recall it, but it does sound familiar that that came up.
Q. Do you recall that you said words along the lines of that your knowledge of the law has allowed you to counsel the board to continue with this litigation, and it would not otherwise have done so. Is that correct?
A. I don't recall making that statement. I have the advice of my own attorneys.
Q. Okay. But we did have the opportunity to record this, at least parts of this answer that you gave at this proceeding.
Mr. Oxford, would you play that for me.
(Video clip played as follows:)
A. "That we're embroiled with Saint Al's, a physician specialty hospital, the Idaho Attorney General, and the Federal Trade Commission. You know, I have to tell you that knowing what I know, and understanding the law like I do, has really been, I think, key -- I think we would have just given up on this a way long time ago and decided not to fight it if I

didn't have the understanding that I have and can convey that to our board. We have great attorneys, but they're going to turn and look to the CEO for the direction. So it's been very help" --
(Video clip concluded.)
Q. That's your voice, obviously?
A. Yeah, it is.
MR. BIERIG: I am going to object to this one statement out of context like this. If they're going to use it, I think they should have provided us with the entire document. They should certainly provide Dr. Pate with the entire recording.
MR. GREENE: This was turned over as an exhibit, Your Honor, actually, some time ago.
THE COURT: Is this, again, marked as demonstrative, for impeachment -- in the demonstrative series as an impeachment exhibit?
MR. GREENE: We will mark it as next in order. The exhibit actually has been marked as Exhibit 3007. And the recordings, there were two documents that were turned over to the defense, IAG000417 to -418, which is Dr. Pate's hard copy handout at that presentation, and then the voice files, IAG000423 to -427.
THE COURT: Mr. Bierig, I'll give you a chance to,

if need be, play a larger portion of the excerpt just to provide context, but not -- you can't offer the entire thing itself. But certainly you are entitled, I think, to provide context for the witness's statement.
MR. BIERIG: Well, the problem is I would ask Mr. Greene, through the court, Your Honor, when this was marked as a demonstrative. I don't believe that we --
THE COURT: Well, I am concerned. I don't have a list of the demonstratives, what's been marked. I think what -- a problem has arisen that we were referring to demonstrative exhibits without any reference to them, so we couldn't make a record. And I've directed counsel to take any demonstratives and make sure that a number is assigned to them for the record. And I think the plaintiffs are using the 3,000 series, and perhaps the defense is using the 4,000 series.
MR. BEIRIG: 5,000.
THE COURT: 5,000. And that also could include, of course, any items that were marked for impeachment purposes and not premarked as a trial exhibit; it can all go into that grouping. They will all need to be marked and made part of the record. I am assuming that has been done with regard to both the transcript or at least the audio file.
MR. GREENE: The audio file, yes, Your Honor. I

misspoke, it's actually Cross Exhibit 3007 as opposed to Exhibit 3007.

And now I just have a -- just a few more lines to ask about.

BY MR. GREENE:

Q. So, Dr. Pate, market power would still matter in a world of value or risk-based contracting; correct?

A. I don't know the answer to that. I'm not sure the answer is known.

MR. GREENE: Mr. Oxford, can you play a clip from Dr. Pate's deposition transcript, 19016 through 20.

(Video clip played as follows:)

Q. "In a world of paying for performance or paying for value, there's still going to be negotiations between payors and providers as to how much to pay; correct?

A. "Yes."

(Video clip concluded.)

BY MR. GREENE:

Q. And isn't it the case, Dr. Pate, that if you are the only provider in town, you're going to be in a very good negotiating position in a world of pay-per-value; isn't that correct?

A. Well, you certainly could be. It depends on how you use your relative circumstances.

Q. Okay. Let's play another clip.

Mr. Oxford, would you play 191 --

THE COURT: We're kind of past where we need to take the break. Are you almost --

MR. GREENE: I'm there.

THE COURT: All right.

MR. GREENE: Play 19, 113 through 24, Mr. Oxford.

(Video clip played as follows:)

Q. "If you're the only provider in town, you're going to be in a very good negotiating position in the world of pay for value to get a higher rate than if you had competitors who were good alternatives to you, correct?

A. "And I -- I think that's theoretically correct. I think the question is would somebody abuse that -- that position. But, yes, I think they could."

(Video clip concluded.)

MR. GREENE: I believe that ends with "they could."

Your Honor, I think we can take our break. I do need to lay the foundation apparently for a couple of documents that we --

THE COURT: All right. We'll take the break, then.

MR. GREENE: -- but I think that's after the break.

THE COURT: If we're past the AEO material, I think we ought to bring the public back into the courtroom.

I'm also going to direct that Dr. Pate's deposition be published -- if he'll provide the original to Ms. Gearhart; I don't think that's been done yet -- since we've used it. And then we'll publish that --

MR. GREENE: We have the ability to publish that right now, as a matter of fact.

THE COURT: Well, if you have the original, then we'll hand that to -- Ms. Gearhart will take care of that now. If you need to look for it, we'll take care of it after the break.

MR. GREENE: Very good.

THE COURT: All right. We'll take care of it after the break.

And then, also, one last housekeeping matter. If counsel would work with Ms. Gearhart to make sure that we have a list of the demonstratives, the 3,000 and 5,000 series documents, so that we can keep track and have a record as well of what has been made part of the record.

We will be in recess for 15 minutes.

(Recess.)

****** COURTROOM REMAINS OPEN TO THE PUBLIC ******

THE COURT: We had a shift in the cast of characters here. First, I assume we have the original deposition of Dr. Pate. I will direct Ms. Gearhart to publish.

Counsel, technically, I trust you all, but the depositions are to be sealed and submitted to the court in a sealed fashion. I am not sure why that wasn't done, but I will direct Ms. Gearhart to publish the deposition.

MS. GEARHART: The deposition of David C. Pate is published.

(Deposition of David C. Pate published.)

THE COURT: Mr. Ettinger, I assume you're picking up?

Mr. Greene, you're done?

MR. GREENE: Yes, I am done, Your Honor.

THE COURT: All right. I've got you down for a few clean-up matters.

MR. GREENE: I did resolve those.

THE COURT: Very good.

Mr. Ettinger.

MR. ETTINGER: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. ETTINGER:

Q. Dr. Pate, St. Luke's approach to changing healthcare is an experiment; correct?

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A. It's an experiment based on things that we have learned have worked with other systems. But, yes, many things are new that we are trying.

Q. And you can't say whether, to date, St. Luke's has achieved anything more in terms of quality improvements than, say, Saint Alphonsus, can you?

A. No, that's not a true statement.

Q. Have you tried to measure St. Luke's against Saint Alphonsus, Dr. Pate?

A. I have relied on other organizations that do so.

Q. And you know St. Luke's has won a number of national awards and Saint Alphonsus has won a number of national awards; correct?

A. That is correct.

Q. And -- and you made some comments on direct about Saint Alphonsus' breach of fiduciary duty or something like that. I assume that you would agree that Saint Alphonsus has a -- is a local board that is every bit as dedicated as St. Luke's board to doing the right thing, wouldn't you?

A. I have no knowledge.

Q. You wouldn't dispute it, would you?

A. I have no knowledge to dispute it with.

Q. Now, you talked about spine infection rates. Isn't it true that St. Luke's spine infection rates are greater than the national average even today?

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A. First of all, I actually didn't talk about spine infection rates, but, second of all, to answer your question, actually last year HealthGrades ranked St. Luke's number one in Idaho for outcomes from spine surgery.

Q. My question is: Aren't St. Luke's spine infection rates greater than the national average? Yes or no or you don't know.

A. Given that -- I don't know given that as an outcome of the surgery and we were ranked number one, I would have to assume they are good, but I don't know what they are.

Q. Now, spine surgery is a kind of orthopedic surgery; correct?

A. Orthopedic or neurosurgery.

Q. Isn't it true that virtually all of St. Luke's quality achievements in orthopedics have come through an MSO or management services organization?

A. I -- I don't believe that to be the case because we have received awards from HealthGrades that include our Wood River and Magic Valley facilities, and I don't believe those physicians are involved in the MSO.

Q. Let me ask the question a little more precisely. Isn't it true that virtually all of St. Luke's Treasure Valley's quality achievements in orthopedics have come through an MSO or a management services organization?

1688

A. I -- I don't know whether that's true or not.

Q. And the MSO is an organization that's partly owned by St. Luke's and partly owned by orthopedic surgeons; correct?

A. That's correct.

Q. And the MSO has been in existence since well before any of the orthopedic surgeons were employed by St. Luke's; correct?

A. I don't know. That -- the MSO was in place when I got here and I don't know what membership of it was when I first got here.

Q. Now, Dr. Pate, you believe that it is not necessary for a physician to be exclusively aligned with one system in order to participate effectively in clinical integration with that system; correct?

A. That's correct.

Q. And, in fact, you believe it's possible for physicians who are aligned with one hospital in the Treasure Valley to work closely on clinical issues with hospitals and physicians in the other system; correct?

A. That's correct.

Q. And you believe also that it is not necessary for a physician to make referrals exclusively within one system in order to participate effectively in coordinated care and clinical integration, correct?

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A. I will -- I will grant it as to the latter; I'm not sure of the former.

Q. Why don't we play Pate Cross 15.

(Video clip played as follows:)

Q. "Is it necessary for a physician to make referrals exclusively within one system or another in order to participate effectively in coordinated care and clinical integration?

A. "No. And, in fact, I would expect that we'd have almost no examples of that, except perhaps in pediatrics."

(Video clip concluded.)

Q. Was that your testimony, Dr. Pate?

A. Yes.

THE COURT: Counsel, because you're not reporting it, I need to have the page and line number for that excerpt. You referred to it as Pate 15, which I assume is your internal designation for a deposition expert.

MR. ETTINGER: That's correct, Your Honor. And it's page 180 of Dr. Pate's deposition, lines 9 through 15.

THE COURT: Thank you very much.

BY MR. ETTINGER:

Q. Dr. Pate, you expect that St. Luke's will achieve clinical integration with its independent physicians by the end of this year; isn't that right?

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A. Not just with independent physicians but with our St. Luke's clinic and independent physicians by the end of this year; that's correct.

Q. And that's the case even though St. Luke's did not devote sufficient resources to clinical integration with independent physicians until the beginning of 2013; correct?

A. Roughly, give or take a month or two, yes.

Q. And St. Luke's has developed clinical integration scorecards; correct?

A. That's correct.

Q. And you believe those scorecards will work not only with employed physicians, but also with independent physicians; correct?

A. I think they will. Right now, it's a challenge with independent physicians because many of them are on paper or different electronic health records, so it's very hard to populate the CI scorecard, but we're certainly making that work.

Q. You believe it will work, in fact, clinical integration and scorecards will work with the independent doctors; correct?

A. Yes.

Q. Now, you mentioned a core group of employed physicians to Mr. Greene and I want to ask you about that. While you believe that you need to have a core group of

1691

employed physicians, you don't have any specific, targeted number for that core group; correct?

A. That's correct.

Q. And, in fact, no one at St. Luke's has even provided a quantitative range as to the number of physicians that would need to be in that core group; correct?

A. Well, I don't know if somebody has; I haven't seen it.

Q. And you've talked about managing population health. St. Luke's has made no effort to determine the market share necessary to give it the skill it needs to manage population health in the Treasure Valley; correct?

A. I think that's correct.

Q. And you had what you described as a core group of physician leaders who helped you develop the clinical integration scorecard; isn't that right?

A. Yes.

Q. And that number was about two to three dozen doctors in total from the Treasure Valley and the Magic Valley and Wood River; correct?

A. I think that's -- that's the right number. I don't think they are the only ones that have been involved in the clinical integration scorecard development, but, yes, that is the correct number of the numbers of leaders.

Q. And the number of leaders that you have stated

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were responsible for the scorecard developments as a core group of employed physicians; correct?

A. Yes. But I don't think I ever stated that they were the only ones involved, but, yes, they have been critical to the development of it.

Q. And are you aware that your retained expert, Dr. Enthoven, said that what you need for this core group is about four to six physicians per specialty?

MR. BIERIG: Objection, Your Honor. I'm not sure that accurately states what Dr. Enthoven stated.

THE COURT: Well, he can indicate whether he agrees with it or not and then when the expert testifies, we can obviously clarify that.

BY MR. ETTINGER:

Q. Are you aware of that testimony, Dr. Pate?

A. I am not. My attorneys have not allowed me to view other experts or other people's -- witness's testimony.

Q. So would you dispute the conclusion that the core -- the necessary core group of employed physicians is about four to six per specialty?

A. Yes, I would.

MR. BIERIG: Object to the form of the question.

THE COURT: Overruled.

BY MR. ETTINGER:

Q. Now, you're not aware of any physicians whose

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practices were acquired by St. Luke's who would not be adequate to serve as part of your core group, are you?

A. No.

Q. And that would certainly include the seven primary care physicians you have already got in Nampa in the St. Luke's Family Medicine; correct?

A. They would be part of what we are trying to do, as well.

Q. Now, Dr. Pate, you are not very knowledgeable about Saltzer, are you?

A. Well, that's a pretty open question. I don't know what that means. There -- I'm sure there is many things about Saltzer Medical Group that I don't know. I feel like I know the leaders pretty well, but, no, I'm sure there are things I don't know.

Q. Well, let's go through a couple of them.

A. Okay.

Q. You don't know whether Saltzer was in your select medical network before the group was acquired; correct?

A. That's correct.

Q. And you don't know the degree to which Saltzer cooperated with St. Luke's before the group was acquired; correct?

A. No, I don't.

Q. You mentioned the seven surgeons who left Saltzer,

went to Saint Alphonsus. You were pleased they left Saltzer and went to Saint Alphonsus; correct?

A. Well, I think what my -- I think what I told you before and what I do feel today is, I feel bad for Saltzer Medical Group that they lost those physicians, which puts them at risk. Am I glad that as things turned out seven physicians who are not aligned with the vision and all have left and prefer a completely different model? I'm fine with that.

Q. You were, in fact, pleased --

A. I am pleased.

Q. And you never talked to any of these surgeons to find out if they were, in fact, aligned or not aligned with your vision, did you?

A. That is not a correct statement.

Q. Did you personally talk to any of the seven surgeons?

A. I have talked to one.

Q. Which one is that?

A. Dr. Steve Williams.

Q. Did he tell you I don't believe in the St. Luke's vision for improving clinical quality?

A. No, he did not.

Q. You mentioned Micron, so let me ask you a couple of questions about Micron.

MR. ETTINGER: Your Honor, this -- well, let's see. I'm going to try to -- maybe we won't need to go to the AEO clips. Let's see how the questions go.

BY MR. ETTINGER:

Q. St. Luke's was not interested in any proposal to Micron that would have involved a cost-per-unit proposal that would have met Saint Al's prices; correct?

A. I think that's a true statement.

Q. But St. Luke's did not offer a risk model to Micron; correct?

MR. BIERIG: Objection. No foundation laid for this question.

THE COURT: Well, the witness --

MR. BIERIG: And there's also no specification for the time period we're talking about.

THE COURT: All right. Let's specify a time frame, although I guess -- I think we are basing it all upon that period of time when Micron was setting up its own employer system.

MR. ETTINGER: Well, in fact, later, Your Honor.

BY MR. ETTINGER:

Q. In 2012, you had several discussions with Mark Durcan, the CEO of Micron, didn't you?

A. I did.

Q. And you also consulted with Randy Billings, your

vice president, about his proposals or decisions not to make proposals to Micron; correct?

A. I did.

Q. Okay. And during that period, St. Luke's did not offer a risk proposal to Micron; correct?

A. From my discussions with -- with Mark were about us moving to a risk arrangement with them. We didn't give them a specific proposal for that, but I was talking with Mr. Durcan and some of his team about kind of high-level things, about how to transform healthcare for Micron and it did involve moving to risk.

Q. But you were not prepared to take risk -- take on risk with Micron at that time, were you?

A. That's correct.

Q. And nevertheless, Mr. Durcan told you that Micron very much wanted St. Luke's in its network; correct?

A. He did.

Q. And he -- in fact, he -- according to you, you reported to your staff that he committed to a relationship with St. Luke's; isn't that right?

A. He did.

Q. Now, you mentioned in your direct that the system board of St. Luke's didn't consider market share at all. The -- the St. Luke's Treasure Valley board was presented with market share figures, physician market share figures

related to the Saltzer transaction, was it not?

A. I think I have already testified I wasn't present at the Treasure Valley board meeting. I don't -- I don't know what they did or did not consider.

Q. Let's -- Mr. Bierig asked you about your article, your 2012 article "Physician Relations in a Post-Health Care Reform Environment."

A. He did.

Q. I want to pick out a little bit more than that one sentence and ask you about it.

A. Okay. Sure.

MR. ETTINGER: So why don't we call up Exhibit 1985.

BY MR. ETTINGER:

Q. So first of all, is this, in fact, Exhibit 1985, is this, in fact, the article you wrote, Dr. Pate?

A. From the portion I can see, yes, that's my article.

Q. Okay. And since this was a published article, I assume you wrote it with some care and considered your words with some care?

A. Well, I was under some time pressures, but, yes, I do think I typically exercise care in my choice of words.

Q. And --

A. I'm not always successful but I do try.

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Q. Well, you're aware of the fact that if you're published, it's sort of there forever. Right, Dr. Pate?

A. I am. And you have made it painfully aware to me.

Q. Right. And you tried, of course, to be as accurate as possible in presenting your views; isn't that right?

A. Yes, I think that's true.

Q. I have read all your blogs, by the way, I've kept up on them.

A. And I appreciate that. I -- I -- I think a number of people at Saint Alphonsus are following the blog and I am flattered.

Q. I can't speak to them and -- and I -- and I won't give you a critique, but I have --

A. Well, thank you.

Q. So why don't we turn to page 3 of the article, Dr. Pate, and let's look at the paragraph in question on page 3. And I want to -- I'm going to read you few a sentences, not just the last one in the paragraph that Mr. Bierig read you.

So starting with the third sentence from the end, it says, "Further, the increase in hiring of physicians is itself a driver of more physician employment. If one hospital in a market is offering physician employment, other hospitals may feel the pressure to offer employment in order

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to preserve market share and access to patients. Further, when a specialist experiences a number of his or her referring physicians being hired by a hospital, this creates pressure for the specialist to consider employment with the hospital to preserve the referral base," close quote.

Were those your words?

A. Those are. I think maybe --

Q. Would you -- would you rewrite any of those words sitting here today?

A. No. But I think it's very important to consider the context of what I was --

Q. You answered my question.

THE COURT: Mr. Bierig will give you chance to explain.

THE WITNESS: Okay. Thank you, Your Honor.

BY MR. ETTINGER:

Q. Now, I heard you say, I want to make sure I got this right on direct. Quote, St. Luke's has never had a practice to direct referrals, closed quote.

Was that -- was that your testimony?

A. That was based on my knowledge, that's correct.

Q. In fact, you don't know if St. Luke's preferentially has directed referrals to its affiliated practices; correct?

MR. BIERIG: Object to the form of the question

1700

and the use of the word "preferentially."

MR. ETTINGER: Your Honor, this word happens to come from the St. Luke's document.

THE COURT: All right. Overruled.

THE WITNESS: I -- I have testified and I believe I have no knowledge of any directing of referrals.

BY MR. ETTINGER:

Q. Let me ask you the question one more time before we go to the tape, Doctor.

A. Okay.

Q. You don't know if St. Luke's has preferentially directed referrals to its affiliated practices; correct?

A. I have been told we haven't, but I don't know that for a fact. I have not looked personally at all these referrals. I do not know.

Q. And are you aware that Saltzer physicians on its executive committee reported that St. Luke's refused Saltzer autonomy in referrals?

A. No. That's -- is completely counter to my conversations and experiences with the Saltzer leadership.

MR. ETTINGER: Your Honor, this -- we're going to have to show him a document, then, that's AEO.

THE COURT: Can we just turn off the projector or do you need to --

MR. ETTINGER: Yeah, we could do that. Let's try

1701

it.

THE COURT: Let's try it and see if we need to.

BY MR. ETTINGER:

Q. I'm going to show you --

THE COURT: Counsel, just a moment. Did I just -- just while I am on this subject. You showed the witness Exhibit 1985, which is Mr. -- or Dr. Pate's article. Was that shown as a defense exhibit number? Because 1985 was not admitted, and there were objections to it.

MR. ETTINGER: Your Honor, I intended at the end of my examination to move its admission. There was a foundation objection. I think we have laid the foundation if there is any issue there.

THE COURT: All right. We will go ahead and proceed then. I -- I thought for some reason it may have been shown by Dr. Pate by Mr. Bierig --

BY MR. ETTINGER: Well, it was.

THE COURT: -- under a different exhibit number.

MR. BIERIG: I hadn't shown it, I just quoted it, Your Honor.

THE COURT: All right. Let's go ahead and proceed.

BY MR. ETTINGER:

Q. Well, why don't we -- we are going to take a look at 1155, Dr. Pate.

MR. ETTINGER: Is there a way I can see it over here? If not, I'll --

I don't know if that monitor is on.

Your Honor, I don't have a hard copy handy because I didn't anticipate using this; it came up on direct. Oh, great, there we go.

BY MR. ETTINGER:

Q. So, Dr. Pate, you see this email from Dr. Djernes?

A. I can't read who it's from, but I see -- I see the highlighted portion that you are talking about.

Q. Do you know who Michael Djernes is?

A. I -- I do not.

Q. Okay. So don't know if he's a Saltzer executive committee member or not?

A. I can -- no, I don't know. I can infer he is with Saltzer because of his email address, but I -- I don't think who he is. I may have met him, but I just -- I don't remember all of the names.

Q. Okay. And you see the highlighted third sentence of Dr. Djernes' email?

A. I do.

Q. And are you able to say whether St. Luke's executives, not you personally, but St. Luke's executives declined to offer Saltzer autonomy in patient referral patterns as part of the transaction?

A. Well, I think this date is way before the transaction. The -- the discussions that we had around the transaction and when Saltzer decided to come with St. Luke's, I think everybody was clear, there is no --

Q. Doctor, my -- my question is: Are you aware -- are you aware --

MR. BIERIG: Your Honor, I object to the interruption of the answer.

MR. ETTINGER: Your Honor, it was not responsive to my question.

THE COURT: Counsel, let me just intervene. Counsel, I -- I will instruct the witness to answer where necessary to make sure we have a direct response. It kind of avoids some of that give and take.

Dr. Pate, let's listen to counsel's question one more time. Answer directly. As I noted earlier, Mr. Bierig, I'm sure will give you a chance to explain anything that you feel needs to be placed into context. But if you'll listen carefully to the question as asked, it will allow us to move forward.

Now restate -- restate the question, if you would, Mr. Ettinger.

MR. ETTINGER: Well -- and -- and I will rephrase it a bit to make it as precise as I can.

BY MR. ETTINGER:

Q. Dr. Pate, are you aware whether or not at some point during the discussions with Saltzer, St. Luke's executives declined to offer Saltzer autonomy in patient referral patterns?

A. No.

MR. ETTINGER: Your Honor, that is all I have. I would move the admission of Exhibit 1985, the article.

THE COURT: Is there any objection to 1985?

MR. BIERIG: No objection, Your Honor.

THE COURT: All right. 1985 will be admitted.

(Plaintiffs' Exhibit No. 1985 admitted.)

MR. ETTINGER: Nothing further. Thank you.

THE COURT: All right.

Redirect.

MR. BIERIG: Can I have about two minutes, Your Honor?

THE COURT: Yes.

MR. BIERIG: One minute, maybe.

May I proceed, Your Honor?

THE COURT: Yes.

REDIRECT EXAMINATION

BY MR. BIERIG:

Q. Dr. Pate, how does the fact that St. Luke's works with independent physicians relate to your previously expressed view that the close personal and financial

alignment with physicians is critical to transforming the delivery of healthcare?

A. It -- it is perfectly consistent. I have always believed that we need to work with independent physicians, St. Luke's doesn't have a sufficient number of financially aligned physicians to be able to manage risk and -- and population health. And I think my lessons from learning at these other organizations, they all have at least a core of employed physicians and they build on that with the independent physicians. So it's perfectly consistent. It's not -- St. Luke's approach isn't an "either/or," it's an "and." We want both the financially aligned and independent physicians.

Q. Now, I believe in response -- excuse me -- I believe in response to one of the questions asked by plaintiffs' counsel, you acknowledged that employment is not the only way to achieve accountable care. How does that view affect your position that a close personal and financial alignment is the best way to achieve accountable care?

A. Well, again, it's consistent. I -- Geisinger Health System has actually published their results in "Health Affairs" and showed that they were able to drive more improvements and faster with their employed physicians than their independent physicians.

And in Mr. Greene's line of questioning, when he was asking me about quality, the point that I kept trying to make during the investigatory hearing is, I believe you can drive quality through clinical integration in nontightly-aligned financial roles. You can do that because there is no -- no loss of income to the physicians for that.

What I don't think you can do, is I don't think you can improve the other two aims of the Triple Aim.

There is no financial model to support better health and there would be significant legal hurdles to get over for us to pay independent physicians to do that. And there is no way to be successful to the degree that we need to lower healthcare costs unless we can eliminate the low-value and no-value services that are performed by physicians. The problem is those services contribute to their incomes and they are just not going to willingly give this up.

Q. In the -- the cross-examination, you were shown a part of your deposition in which you indicated that St. Luke's would consider a joint venture with Saltzer if the court were to order the divestiture of Saltzer. Do you recall that?

A. I do.

Q. Would you be able to joint venture with Saltzer if Saltzer ceased to exist as an entity?

A. Could not.

Q. How, if at all, would proceeding through a joint venture impact the -- let -- let me rephrase that.

How, if at all, would proceeding through a joint venture with Saltzer, rather than the close affiliation in the current structure, impact the ability of St. Luke's to effectuate the Triple Aim in Canyon County?

A. It would be huge. I have a significant experience with joint ventures -- joint ventures in Houston and they were an abject failure. It is a way, I think, we could try to help the economic survival of Saltzer Medical Group, but it will -- I have -- I am under no illusions that that is going to help us achieve the Triple Aim or accountable care or move to risk-based contracting.

Q. And why would a joint venture relationship not be as efficacious in moving the Triple Aim into Canyon County?

A. Well, most of the -- most of the joint ventures that are structured between hospitals and physicians are around the use of the various -- the very kinds of services we are trying to decrease the use of. They are around hospitals, surgery centers, imaging, those kinds of things. And the problem is we have got to stop feeding the fire that is leading to increased healthcare spending. I -- I hear it every day from employers and people who cannot afford their healthcare, they are -- and -- and frankly, the problem is,

yes, we can do a lot of things to improve quality, like Mr. Greene questioned me about, not one of those people who have come to me to express their concerns about healthcare has said we have to have better quality, you have to do something.

They -- that's not what they are telling me. They're okay with the quality. I think they should hope for more, but they do not perceive there is quality problem, they don't perceive they can afford it. That's the problem we have got to solve and a joint venture is not going to solve that.

Q. Okay. Mr. -- well, plaintiffs' counsel asked you questions about the MSO.

A. Yes.

Q. That's the Management Services Organization?

A. It is.

Q. And we are referring to the Ortho-Neuro Management Services Organization?

A. There was more than one, but I believe all the questions were in reference to ortho-neuro.

Q. Do you know what the makeup of the ortho-neuro MSO is in terms of rough percentage of employed physicians versus independent physicians?

A. I am under the impression that it's mostly employed physicians, but I do not know.

Q. Okay. Counsel for Saint Alphonsus showed you Plaintiffs' Exhibit 1985. And I believe you were wanting to give context to some of the statements that you made and you were interrupted as you tried to give context.

MR. BIERIG: So with plaintiffs' permission, I would ask them to put that particular paragraph up for Dr. Pate to look at. Could -- could that be done?

You have got it? Okay. Then I would ask the court to put up that one paragraph of 1985.

THE COURT: This is not AEO?

MR. BIERIG: No, this is not. This was -- this was his article, Your Honor.

THE COURT: All right.

MR. BIERIG: It was the -- the paragraph that Mr. Ettinger quoted. Could you give us some help, Mr. Ettinger, what page that was on?

MR. ETTINGER: Page 3. Sorry.

MR. BIERIG: Page 3.

MS. DUKE: And it's the second paragraph.

MR. BIERIG: Yeah. Why don't you just highlight that entire paragraph for Dr. Pate.

MS. DUKE: It was the one up.

MR. BIERIG: The one -- that one.

MS. DUKE: There you go.

BY MR. BIERIG:

Q. Yeah. That's the quotation. I believe you were starting to say that you, in fact, did say that, but you wanted to give context. So by this question, I am asking you to give context.

A. I did. Thank -- thank you, Mr. Bierig. It is just important to realize who the audience was that I was speaking to -- I -- and what I was speaking about. I was speaking at a national law conference and this journal article was to be the output from that conference.

And so I was commenting on the national scene of healthcare, and I just wanted to be clear. My comments were not describing the specifics of the Idaho market, but -- but these are general statements that I do believe are true and reflect activity across the country.

Q. Thank you. And counsel for --

MR. BIERIG: You can take that down.

BY MR. BIERIG:

Q. Counsel for Saint Alphonsus also showed you a -- an interchange involving Dr. Djernes.

MR. BIERIG: I would ask the court to put that up, if you would.

MR. KEITH: I'm going to object. That was AEO.

MR. BIERIG: Oh, that was AEO. Okay. Don't put it up.

BY MR. BIERIG:

Q. The -- the question there was --

MR. BIERIG: I tell you what, could you just put it up but blank out everything but the date? Just -- just put the date up.

THE COURT: Turn off the jury projector so we can.

MR. BIERIG: We're just talking about the date.

MR. KEITH: You can put it up now.

MR. BIERIG: Oh, we can put it up? Okay. Let's put it up. You can put the whole thing up.

BY MR. BIERIG:

Q. Could you -- could you identify for the record what the date of that document was?

A. Yeah. It was June 28th of 2011.

Q. And where in the course of the negotiation between St. Luke's and Saltzer did that 2011 date fit?

A. To my recollection, it preceded them. I mean, there -- there had been discussions on and off, but the -- the present transaction was subsequent to this and this was not the terms or the conversations that we had with the Saltzer Medical Group around the present transaction.

Q. So in terms of the questions that Mr. Ettinger asked you about in terms of the directing of referrals, does the statement that's in this document reflect what the actual terms of the final transaction are?

A. Absolutely not. It's in counter-distinction to

our -- our agreement.

MR. BIERIG: Thank you. I have no further questions, Your Honor.

THE COURT: Any recross?

MR. ETTINGER: Just a bit, Your Honor.

RECROSS-EXAMINATION

BY MR. ETTINGER:

Q. Dr. Pate, isn't it true that the current Saltzer transaction is a result of discussions that have gone on for a couple of years?

A. And evolved significantly, but true.

Q. Okay. And they certainly began well before June of 2011, didn't they?

A. I think discussions about our relationship preceded my arrival, which was more than four years ago so --

Q. I'm -- I'm talking about discussions about an acquisition in some form or other.

A. And -- and your question is what?

Q. That began well before Dr. Djernes' email. In fact, his email related to whether or not to accept -- let me ask one question.

Isn't it true that Dr. Djernes' email related to whether or not to accept St. Luke's original acquisition proposal?

A. I don't know. I didn't get to see the whole -- whole document.

Q. Okay.

A. I just saw that one --

Q. That original proposal was made in the spring of 2011, wasn't it?

A. That could be and could be the original proposal. It's not what the final was. I -- I don't remember ever seeing the -- the original.

Q. Now, you talked in response to Mr. Bierig's questions about when people come to you, they are concerned about cost. And I gather that the way you intend to address that you have said is through controlling utilization; is that right?

A. Well, that's -- that's only a small part of it. I have said much more than that, but that is an element of it.

Q. Oh, there's only two ways to control cost. You either cut the price -- we know your views on that -- or you cut the quantity by controlling utilization; correct?

A. No, I disagree with that statement.

Q. There is a third way? What is it?

A. Well, there's many ways. I think -- and one of the things that I have said is foundational. If we want to truly get a handle on healthcare costs, we have to improve health. I mean, so it's not just controlling the

utilization of which services they get, I think that's important and I think that it's clear from the "Dartmouth Atlas" that people in this country are getting too much care in some instances and we are hurting people.

Q. Isn't it true that St. Luke's has concluded that there is not much room for further reduction in utilization?

A. St. Luke's me? I have not concluded that at all. Now, we have been told that by third parties and I do not believe that to be the case. I think there is tremendous opportunity.

Idaho is a very low cost state and we have low -- low insurance premiums, but I'm not the least bit satisfied. I think there is much more than we can do. And I've heard people that try to benchmark us to other areas, and, of course, if you look at the current state of how healthcare is done, Idaho is one of the best performing places in the country. So, yes, you wouldn't conclude there's opportunity. But if you now think about transformation and completely changing the model, I think there is huge opportunity.

Q. Okay. So number one, you disagree with the -- your consultants, Wipfli, who you've used on about a dozen projects --

MR. BIERIG: Your Honor, I'm going to object to this as beyond scope of the redirect. This sounds like

entirely new material that I did not bring up on redirect.

MR. ETTINGER: Your Honor, Dr. Pate said in response to the question: What could you and could you not do in a joint venture with Saltzer? And he said, Well, we could address quality, but people come and complain to us about cost. And that's what I'm addressing here is the ability to control cost. St. Luke's own documents directly contradict Dr. Pate's position.

THE COURT: Mr. Bierig.

MR. BIERIG: I don't believe this has anything to do with the comparison of the joint ventures of the employment model. This is raising all sorts of new issues that could have been covered in the -- in the cross-examination. I don't see this following from any question of the four or five that I asked. This is entirely new.

THE COURT: Well, Mr. Ettinger, I don't recall it coming up on -- well, let me -- that's the danger with recross is that it has to be tied to what was covered in redirect.

MR. ETTINGER: And -- and, Your Honor, if -- if I didn't think it was, I wouldn't have raised it now --

THE COURT: I understand. Well, I'll -- I'll allow to you procedure in a limited fashion.

Go ahead.

THE WITNESS: Well, and my answer, Mr. Ettinger, is --

BY MR. ETTINGER:

Q. I'm not sure where we were in the question. Let me -- let me ask the question better.

A. Well --

THE COURT: Let's let -- again, even though I normally would -- well, I will allow a re-redirect here to cover this topic. But let's get -- in order to streamline it, let's get another question back before the witness.

BY MR. ETTINGER:

Q. I want to ask you a very specific question, Dr. Pate. And that is: Isn't it true that Wipfli, a consultant used more than a dozen times by St. Luke's, has said that there's not much room for further reduction in utilization for St. Luke's?

A. That's correct. That's what they have said. I don't believe it's a correct statement --

Q. Well --

A. -- but that's what they've said.

Q. -- let's -- let's go to that next.

What is the president's cabinet of St. Luke's, Doctor?

MR. BIERIG: Your Honor, again, I must object. This is well beyond the redirect.

MR. ETTINGER: Your Honor, the witness has said

it's not what he thinks, what St. Luke's thinks. I have got a document that says it's what his cabinet says.

THE COURT: Go ahead, Mr. Ettinger.

BY MR. ETTINGER:

Q. What is president's cabinet, Dr. Pate?

A. The president's cabinet is senior leaders of the health system who report to me or somebody that reports to me.

Q. Okay. So let me show you Exhibit 1057, Dr. Pate, if we can pull that up. The first page first.

So let me represent to you, Dr. Pate, this is document entitled "Treasure Valley Planning, President's Cabinet March 12, 2012." And you were president at that time, correct?

A. I'm sure I was. I don't recall that, but I'm sure I was.

Q. Okay. And this is a St. Luke's document and does it say, quote, not much room for further reduction, closed quote, referring to inpatient admissions?

A. That's what the document says.

MR. ETTINGER: Thank you. Nothing further.

THE COURT: Thank you.

Mr. Greene, I think you did not ask any further recross --

MR. GREENE: I passed, Your Honor, yes.

THE COURT: Now, Mr. Bierig.
MR. BIERIG: No further questions.
THE COURT: All right. You may step down. Thank you very much, Dr. Pate.
THE WITNESS: Thank you, Judge.
MR. BIERIG: Your Honor, at this point, may I provide the full exhibit that has already been admitted? I didn't have the full copies --
THE COURT: Yes. What was the exhibit number?
MR. BIERIG: It was 2640.
THE COURT: All right. If you would, provide that to Ms. Gearhart on a break.
MR. BIERIG: Well, we are still in the process of stamping the page numbers, so I'll do it during the break.
THE COURT: All right. Very good.
St. Luke's may call its next witness.
MR. SINCLAIR: Call Patricia Richards.
THE COURT: Ms. Richards, please before the clerk here, be sworn as a witness and then Ms. Gearhart's directions from there.

PATRICIA RAE RICHARDS,

having been first duly sworn to tell the truth, was examined and testified as follows:

THE CLERK: Please state your complete name and spell your name for the record.

THE WITNESS: My name is Patricia Rae Richards. And that's capital P-A-T-R-I-C-I-A; middle initial R-A-E; last name Richards, R-I-C-H-A-R-D-S.
THE COURT: Thank you.
MR. SINCLAIR: Your Honor, this will not be AEO, we can turn the screen on now.

DIRECT EXAMINATION

BY MR. SINCLAIR:

Q. Ms. Richards, for whom do you work?
A. **I am employed by SelectHealth, which is a wholly owned subsidiary of Intermountain Healthcare.**
Q. And what is the mission of SelectHealth?
A. **The --**
Q. Before we go there, let me ask to call up Exhibit 5100 and page 2.
A. **Thank you.**
Q. Is this the mission statement for SelectHealth?
A. **Yes.**
Q. Could you explain it?
A. **Yes. The mission of SelectHealth is to collaborate with our clinical partners to offer coverage and access to high-quality healthcare services at the lowest appropriate cost, to improve the health of our members, and to provide superior service to our customers.**
And with the -- that is the SelectHealth mission

and to fully understand the importance of the SelectHealth mission, it is also important to understand the origin of our parent company, Intermountain Healthcare.
Q. Could you explain that to the court.
A. **Yes. Intermountain Healthcare was established in 1975. And this was done through -- the LDS church was an owner of 15 hospitals, 15 community hospitals. And at that time in 1975, the LDS church made the decision to gift the hospitals to the community. And a key caveat of the leadership at that time was that these hospitals were to be the basis of building a model healthcare system.**
The founders really felt that healthcare was something that was very important to the community. So they wanted the hospitals and the leadership to work together to build this model healthcare system that was based in the community, a not-for-profit organization, with community leadership. So that's an incredible origin and rich history for the organization.
And then Intermountain went on about building that model healthcare system, first by building the -- the -- it was called IHC Health -- Health Plans at the time, and the health plan was built in 1984, about ten years after the gift of the hospitals.
They went on about ten years later and built the Intermountain Medical Group, which was a group of employed

physicians. The employed physician component of Intermountain is now about 1,200 physicians and caregivers. And then about ten years later building on the core of Intermountain and the Intermountain Medical Group have established clinical programs.
So with all parts of the system working together, the hospitals, the health plan, the medical group and these clinical programs, we are now in a position to really deliver -- and it goes back to our mission, to really deliver high-quality healthcare at the lowest appropriate cost for the benefit of the community. So that is really the origin of both Intermountain and the SelectHealth mission.
MR. SINCLAIR: Mr. Chasin, could I have page 3 of Exhibit 5100.
BY MR. SINCLAIR:
Q. What is the vision for SelectHealth?
A. **Well, as you see on this screen, I am very proud of the vision of SelectHealth. And this is something that we -- we had our mission, we had our values, but in about 2010 and working into 2011, we felt it was very important to articulate a clear and compelling vision for the future. And so we worked with our leadership, our board, the Intermountain leadership, and what you see here is our vision. And we hope to achieve this vision over the next**

several years.

As you can see, we aspire to be a nationally ranked, high-performing health plan. We didn't want to just limit ourselves to being the best health plan in Utah, we wanted to be nationally ranked and recognized. We designated that we wanted to be a market leader in all geographic areas in which we operate. We wanted to be, by objective measure, the most preferred health plan in Utah by members, providers, employers and agents, insurance brokers.

As I mentioned, this was done in 2010 and 2011, so that was before our affiliation and expansion into Idaho. If we had to revise this now, I would say the -- the most preferred health plan in Utah and Idaho.

Those first three elements are fairly standard and -- and might be seen by any health plan as part of their vision, but I think the last two -- and this took a long time, it's a few words, but it's -- it's a very profound meaning.

The last two aspects of our vision statement are to be recognized for leadership and commitment to community service, improving health status, and serving all market segments. So we have a -- a vision that goes outside of our own walls to really help serve the community and improve health community-wide.

And then the last aspect of our vision may be the

most unique. And I have honestly not seen this with any other health plan. And -- and our last part of our vision is to be both a catalyst for and an active participant in transforming healthcare delivery through collaboration and shared accountability.

So this is no small goal. Not only do we want to be the best health plan, we want to really be actively involved in changing the way healthcare is delivered locally, nationally, because I personally, and our board and others within Intermountain, believe that healthcare as a system is very broken right now and that it is not sustainable and that it's really important to change the way that healthcare is delivered and financed to create a system that will meet the original vision of Intermountain Healthcare, which was to build a model system for the benefit of the community.

So we all recognize that change is necessary and as we discuss our relationship with St. Luke's, what I am so struck with is the alignment of the mission's vision and values and the recognition that change is essential to make our healthcare system sustainable.

Q. In discussing transforming healthcare, Dr. Pate just testified as to the Triple Aim. Are you familiar with the Triple Aim?

A. Yes, I am.

MR. SINCLAIR: Mr. Chasin, could I have Exhibit 1599, please.

BY MR. SINCLAIR:

Q. Does this exhibit reflect the Triple Aim as SelectHealth care addresses that term?

A. Yes. And SelectHealth care understands that the Triple Aim had its origins with the Institute for Healthcare Improvement and we've adopted the three cornerstone principles, which are really to improve health, better health fundamentally; better care, how care is delivered and organized; and the patients' experience of that care. And what we are wanting to do is increase the value by simultaneously achieving better health, better care, and lower cost.

And this is -- we believe it's essential that all three elements work together to, again, benefit individuals and communities. So this is an outline of the Triple Aim. What we also have added here are some specific examples. But the fundamental Triple Aim that we -- that guides our actions every day is better health, better care and lower cost.

Q. And again, why is the Triple Aim important to you and SelectHealth?

A. Well, this is very important to SelectHealth and to me personally, but to SelectHealth because, as I

mentioned, SelectHealth is a wholly owned subsidiary of Intermountain Healthcare.

Intermountain Healthcare is organized as not-for-profit 501(c)(3) organization, a charitable organization. The health plan as a subsidiary is organized as a 501(c)(4), so we are technically organized as a social welfare organization. So this value of better health, better care, lower cost for the benefit of the community, is essentially the foundation of our mission and vision.

Q. Does SelectHealth provide a full range of services to your customers?

A. Yes. We do provide a full range of services. And it is through -- as -- as again referenced in the mission, it is through working with our clinical partners.

SelectHealth is an insurance company, and we do all of the traditional insurance work. We do not personally provide healthcare, but we depend on the clinical partners with whom we work to provide healthcare. So working together, and that's -- that's the key of the collaboration and working together, we are able to make arrangements for people to receive, as you will note under better health, receive appropriate preventive services, management of chronic conditions, improving the health -- and this is key, too, we are trying not only to improve the health of people that come to the clinics or the hospitals that we work with,

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we are dedicated to improving health of the entire community. So we feel through our relationships with providers, we are able to make arrangements for this access to preventive care, chronic care, health improvement for the community.

Q. Does improving the health of the entire population or community decrease costs within the health system?

A. Yes. We believe it does. In fact, we believe this in -- in two ways -- first of all, I often share with people, it's a little known actuarial secret that healthy people cost less than sick people.

And that is something that if we can keep people healthy, that should help the entire community not be subject to the rapidly rising costs in healthcare that we have seen for the last 40 to 50 years. So we are fundamentally about improving health.

And the other thing that that helps with, as part of our goal, we want to serve the entire population. And one of the things that we have recently launched in our Utah operation, we've launched a managed Medicaid plan, which we believe is really important to improve cost for low income and somewhat disenfranchised populations because ultimately, if we do not take care of the entire population, the cost will just be shifted to the few that are paying the price.

And -- and I think many people have heard that

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there is uncompensated care, undercompensated care, uninsured individuals, and until we can find a way to improve the health status of all of the individuals, those costs for the care will just be shifted to the employers who can barely afford to maintain their healthcare premiums now. So it is an entire ecosystem that fits together. So all of the pieces have to fit together.

Q. Is having an integrated healthcare system of any importance?

A. Absolutely. To me it is -- it is one of the foundations of being able to achieve the Triple Aim and to achieve our mission and values. As I mentioned before, the -- the integrated system allows all parties to work together. It allows the hospitals, the physicians, the health plan and the patients, and even others in the community to work together to achieve these goals. So I believe the key is having an integrated system. But it takes even more than an integrated system.

It takes -- it takes leadership and it takes vision to drive change. All of us, it's difficult to change. And there is a lot of forces that want to keep the status quo. But we fundamentally believe that for the future and to have any sustainable cost for healthcare in the future and to have methods that will actually improve health, we need to fundamentally change the system and the

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way it works. And we have to change that from the inside out.

That starts, though, with -- with leadership and will and an unrelenting vision to make the future better. And I believe that that can best be accomplished -- first of all, it takes very courageous leaders at a system level, but then the advantage of having an integrated system is that you can align and build a culture that is focused around common objectives like the Triple Aim.

And -- and with that culture, I think it's -- it's important, you have to start with a cadre -- first of all, I believe it has to be physician led, clinician led. And you have to start with a core group of physicians who share that passion and who are willing to invest the time to create change. So I believe it's all about change.

And what my experience has been with Intermountain Healthcare is that a key foundational element -- you know, I mentioned that Intermountain Healthcare was established in 1975, then the health plan was built about ten years later, then the medical group was built about ten years after that. And once we had the group of employed physicians who could help build what was called clinical programs, integrated clinical programs, when we had that group of employed physicians who were working towards this common goal, they were able to build changes in the system and they had

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aligned financial incentives to do so, that is the value of an integrated system in driving change.

And I see that same courageous leadership and that same vision and willingness to work in that same fashion with our affiliation with St. Luke's Health System. And --

THE COURT: Mr. Ettinger, did you have --

MR. ETTINGER: Yeah, Your Honor, I would like to object to foundation. The witness was just talking about 20-year-old history as a basis for her answer, and I think she hasn't been at Utah much less working directly with Intermountain for anything like that period of time. I think she was back in Michigan with me fairly recently. So -- so I think -- so I think she doesn't have personal knowledge about the things she is talking about, Your Honor.

MR. SINCLAIR: She was talking about when they were formed, when they added various segments. You do not need to be there to know that information. As a CEO and president of SelectHealth, that would be information she would know.

THE COURT: Okay. Well, actually, I was -- I'm not -- I shouldn't admit this, but I wasn't absolutely sure what her status was. I'm not sure we heard --

MR. SINCLAIR: We haven't. I'm getting to that. It's coming up.

THE COURT: So now -- now that I know that she's

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the CEO and president of SelectHealth, I think that will affect my decision. I will overrule the objection because as the principal, as the head, if you will, of SelectHealth, I think she certainly would be informed enough to know about the history, at least broadly speaking, of both SelectHealth and the parent corporation, Intermountain Health. So I'll overrule the objection.

MR. SINCLAIR: And I will provide that foundation. I wanted to get into some other issues first. But I will back up and cover that in a second.

BY MR. SINCLAIR:

Q. So in your experience, Ms. Richards, what is the result of attempting to reach your full potential without affiliating with physicians?

A. Without affiliating with physicians, it is very, very difficult to drive the level of change necessary to make systematic change. And I -- I have learned that not only from understanding the history of Intermountain and SelectHealth, which is -- is actually well published and documented, and there is books, these are case studies that others look to to learn how to build modern -- model healthcare systems. So this is published information.

But my own personal experience, for instance, and we will talk about that more, I most recently, before coming to SelectHealth, worked at the Henry Ford Health System in

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Detroit, Michigan. I was the executive vice president and chief operating officer of the health plan, which was owned by Henry Ford Health System.

Again, a very similar model with the Henry Ford Health System having a health plan and employed physician group and a hospital system. And that experience there was very similar to what I have both seen and read in Utah because it takes this core of physicians, it takes all parties working together, to make change.

So I have had both, I have learned history, but I have also -- I am old enough now, I have this gray hair because I have been in healthcare for 40 years. So I have lived history. And I have seen so many failed attempts to control cost that I believe through my own personal experience and also reading that the only possible way that we have for the future to both improve health, manage cost is through these not-for-profit integrated delivery systems.

And it really goes back to having the -- the agreed upon vision, the culture for change, and then having systems that are willing to invest in the tools to make change possible: investing in systems, investing in training, investing in time and effort to develop these types of clinical protocols that can actually change care.

So I believe that, fundamentally, an integrated system is required, because otherwise, you have fragmented

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efforts and you have independent parties who maybe don't share that common mission. And I believe it's really foundational because once you have this kind of a system, then other physicians can certainly join it, but it really takes that core as the foundation to make it work.

Q. So you can bring in independent physicians once you have established your system?

A. Yes.

Q. Let's back up a little bit and address the foundational questions that the court asked about.

Give your educational background, if you would.

A. Oh, thank you. I started out in nursing. After high school went to nursing school, earned a registered nursing license. And after that, my first professional work was at the University of Michigan Medical Center in Ann Arbor, Michigan. Worked there for about five years in clinical nursery and also in nurse recruitment.

After that, I took a couple of years off, had some babies, went back to school, did kind of the usual, and when I was ready to go back to work, I had an opportunity to work at Blue Cross of Northwest Ohio. And that was really a great learning experience. I learned all about the insurance industry and the history of Blue Cross.

Following about six years at Blue Cross, I took some time off again and then had an opportunity to work with

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a start-up operation called Paramount Health Care, which is a wholly owned subsidiary of ProMedica health system, again another not-for-profit integrated system. And I spent about 12 years there.

Took a brief side trip to working for a publicly traded Blue Cross plan. I started at Blue Cross of Maine in Portland, Maine, and they were subsequently acquired by WellPoint.

I quickly realized that working in publicly traded insurance environment was not a good fit with my core beliefs. And so then a position opened up at Henry Ford Health System, so I moved back to Detroit, 50 miles from where I started, spent five years working in Detroit with Health Alliance plan and the Henry Ford Health System, and then I was recruited to come to interview for the CEO job at SelectHealth following that.

Q. How long have you been with SelectHealth?

A. I have been with SelectHealth almost four years. I started in November of 2009.

Q. So in follow-up to my prior questions about your vision, your goal, and whether it's feasible, are there others in the country that you know of --

MR. SINCLAIR: And let me have Mr. Chasin call up a blank sheet, if you would. I am going to mark this as Exhibit 5103. And -- and if this works, as she mentions

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entities that she is aware of that are following the same track, he will enter them on this sheet so that we can memorialize that.

THE COURT: All right. Thank you.

BY MR. SINCLAIR:

Q. So are there other entities in the country that are trying to address medical care in the same fashion that you are?

A. Yes. I participate in my role as the CEO --

MR. ETTINGER: Your Honor --

THE COURT: Just -- just a moment, there's an objection --

THE WITNESS: Sorry.

THE COURT: -- before we go any further.

MR. ETTINGER: I'm trying not to object too much. But, you know, earlier in the case, three was an issue when people tried to introduce data, has it been properly assessed, do we know the background, do we know where it's from, and now we're having witnesses who are going to talk about other health systems with which they were not personally involved and reaching conclusions about their success based on certain characteristics of theirs.

And it seems to me in order to permit that, there ought to be a pretty specific foundation laid that the witness has, you know, really studied carefully the ins and outs of

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that system so the witness can offer a competent opinion about what caused that system to do well or not do well more than reading a few articles in the trade press recently.

THE COURT: Mr. -- Mr. Sinclair, I -- I am very interested in the extent to which integrated healthcare, risk-based contracting has been tried, utilized, and succeeded in other markets, but I am concerned, Mr. Ettinger's point is well taken, that it's something to have a witness offer observations about what's happened around the country without either establishing expertise under Rule 702 or some basis for her personal knowledge, I think. So I am going to direct you, I guess, to lay that foundation or else limit the witness's response just to the most general observations.

MR. SINCLAIR: Okay. That's fine, Your Honor. Thank you.

For the record, we will indicate that these questions come off the answers in her deposition on pages 87 and 88 where she identified these same types of entities in response to questions from plaintiffs' counsel.

BY MR. SINCLAIR:

Q. So as you identify any other entity that you believe might be following the same path, would you explain the basis of any of your knowledge so that Mr. Ettinger can object if doesn't think you are adequately informed to have

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the opinions you are giving us?

A. Uh-hmm, certainly. First of all, throughout my career, I have always wanted to study the best-in-class organizations because I have felt that I am not smart enough to do everything by myself. So I have -- I have really made it a study to -- to monitor and learn from other organizations.

But having said that, in my present role, I serve on the board of directors of an organization called the Alliance of Community Health Plans. And this organization has 22 members and the common factor with all of the members of the Alliance of Community Health Plans is, first of all, that they are all not-for-profit organizations, they are all delivery system aligned, they all share a belief in the Triple Aim as the -- the core of changing for the better how healthcare is delivered, and they all have a focus on improving community health status. So those are the -- the requirements of the organizations who participate.

And so I'm -- I'm very familiar with these organizations. And I have spent time learning and reading and interacting, we have very active committees, committee structures that look at cost and quality and service. We meet as a group four times a year, and we have many calls, conference calls in between, to look at what are the best practices in health improvement and cost management. So I

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work very closely with all of these organizations.

And in addition, I've -- I -- I do participate in another organization as well, called the Health Plan Alliance, and there are other similar organizations there, and I have made it a point to actually go and visit several of these organizations and have in-depth discussions with their leadership team.

Part of the -- the other value of the Alliance of Community Health Plans, we all believe in -- that one way to improve is to be very transparent about performance. And so we are always sharing performance, we are always open about performance, and we -- we routinely share about our successes and when things don't work very well. So I have a lot of firsthand knowledge of these organizations from my work as well as site visits in addition to -- to reading.

But a couple that I'm -- I can mention, for instance, that I -- I work very closely with, there is HealthPartners, based in Minneapolis, and HealthPartners is a very similar model. They have hospitals, employed physicians, affiliated physicians, and a health plan.

Another one is Geisinger Health System out in Danville, Pennsylvania. Geisinger is, again, often mentioned. I think in the presidential debates, Geisinger and Intermountain were both mentioned by both candidates.

Geisinger, same type of a model: hospitals,

employed physicians, affiliated physicians, and a health plan.

Another one that I have firsthand knowledge of is the -- it's called the Security Health plan. This is in Marshfield, Wisconsin, where I went to nursing school, and this is the Marshfield clinic, a group of physicians who works with the hospital and owns a health plan, same type of model. They were, in fact, one of the -- the very early models of -- of integrated care delivery, and they really serve much of the state of Wisconsin, especially the rural area in Wisconsin.

So we've got HealthPartners, Geisinger, Security. Another integrated system that's widely known that's part of the ACHP is Kaiser, the Kaiser health plan, Kaiser Permanente. The model with Kaiser is a little bit different in that that's a fully employed model and they have both employed physicians and hospitals and a health plan that are -- are totally integrated.

Another member of ACHP is the Group Health Cooperative of Puget -- well, it started out Group Health Cooperative of Puget Sound, now it's just group Group Health Cooperative in Seattle. Again, the same model: employed physicians, affiliated physicians, hospitals, and health plan working together.

One of the reasons that we can all share this

information, we are in noncompeting markets and we have very strict parameters. We don't ever discuss, for instance, pricing strategies, but we focus our -- our discussions on improving health, improving care, improving the health of the community, and learning from each other.

Let me see, I could -- the list goes on.

Q. That's okay. Let me ask this question. Let's -- the group that you have listed, and other than the Alliance, which I understand is all these people coming together, but of the groups that you listed, are you aware if they have an employed-physician core as their program?

A. Yes. The groups that I have listed, HealthPartners, Geisinger, Security Health plan, and Group Health have at the core an employed-physician group, and then as they have developed, they have added other affiliated physicians. The one that is the most unique, though, that's -- that's virtually a fully employed model is Kaiser. But everyone else on the list has a strong core of employed physicians.

Q. Now, earlier in this trial, there was a witness who indicated to the court that there is no evidence that this mission upon which you're endeavoring will work. What is your belief in regards to that?

A. Well, the belief is if you look at the history, there is strong evidence that these types of systems work.

And especially -- and as -- as now as reporting and transparency and standardized reporting is more available, and it's -- it's more well advanced in the quality and -- and satisfaction ratings, but these types of plans, when you look at standardized metrics, do better than the fragmented plans. They do better.

MR. ETTINGER: Your Honor, now -- now I think we are getting into causation and that is where I have the concern.

THE COURT: Do we have the -- the studies, the metrics?

MR. SINCLAIR: Well, let me ask this question. It may just raise another objection.

BY MR. SINCLAIR:

Q. Are you aware, can you give the court any examples which indicate that these efforts have been successful? Specific examples.

MR. ETTINGER: Your Honor, I'm going to -- if she doesn't have the studies, which we would need to look at, ad hoc examples don't exactly provide us with greater assurance or greater foundation, she is still making an interference about causation from particular examples.

THE COURT: Well, causation in what -- causation in the sense that integrated healthcare does, in fact, yield better quality, I guess --

MR. ETTINGER: Right. That -- that was the question, as I understood it.

MR. SINCLAIR: It was.

THE COURT: When you use the word "causation" in a courtroom, I think legal causation. We're talking medical causation here; right?

MR. ETTINGER: Sure.

THE COURT: Thank you. I just want to make sure I understood the objection.

Mr. Sinclair, I am going to give you some leeway, but if it's just anecdotal, in other words, her observations -- her, I apologize, the witness's, observations, then I think that's -- that needs to be -- I believe we need to have studies or -- or some reference of that sort.

BY MR. SINCLAIR:

Q. Are there metrics or national standards that -- that you are referring to in trying to address whether or not your vision and mission are working?

A. Yes.

Q. What would those be?

A. And these are all publicly available. And it would start with the NCQA accreditation, National Committee for Quality Assurance accreditation. All their work is published. And they build on two components: the HEDIS, the Healthcare Effectiveness Data and Information Set, and

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the CAHPS survey, Consumer Assessment of Healthplan [sic] Providers and Systems. And these have been developed and refined over the past 20-plus years.

And they use standardized measurements, validated measurements, independent data collection, and public reporting of metrics, especially the HEDIS would be called the clinical metrics and HEDIS looks at preventive care, management of chronic care, disease state, and helping consumers improve their health.

And so there is a whole -- whole host -- and, again, these are all published, validated, and publicly available, how the methodology is established. And if you look at the top-performing plans and systems --

MR. ETTINGER: Your Honor, objection. Here we are -- now the witness is referring to her conclusions from a bunch of data without referencing a particular study and trying to suggest that certain kinds of systems are higher performing than others and that indicates causation.

THE COURT: Has the witness been identified as an expert witness as opposed to --

MR. SINCLAIR: No, Your Honor.

THE COURT: -- just a fact witness?

MR. SINCLAIR: Yes, Your Honor.

THE COURT: I will have to sustain the objection then.

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BY MR. SINCLAIR:

Q. Were you -- were you giving your personal opinions as to how these entities related or what was it that you were going to refer to?

A. The publicly reported rankings of health plans.

Q. And -- and what -- who publicly reports these rankings?

A. They are publicly reported by the National Committee for Quality Assurance.

Q. Is that a governmental entity?

A. No, it's a private entity.

Q. And it's -- and it evaluates all the various systems across the country?

A. Yes.

Q. Based upon these national standards that you have addressed?

A. Yes.

Q. So you're -- this isn't your personal opinion, this is what you have seen published as publicly available information?

A. Yes.

Q. And how do these entities rate in this context?

MR. ETTINGER: Your Honor, back to the same point.

THE COURT: Now -- now it's a question of hearsay. If we had the reports and it falls within an exception of

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the hearsay rule, then we're in business. If not, then I'm going to have to sustain the objection.

MR. SINCLAIR: Okay.

THE COURT: And we are going to take a break in about 15 or 20 minutes --

MR. SINCLAIR: We'll look and see whether we want to put them in.

THE COURT: All right. We can circle back to that.

I did want to comment. Ms. Richards, I did not -- I hope you didn't take offense when I made the comment about you not being an expert.

THE WITNESS: Oh, no.

THE COURT: My guess is you are an expert in a number of different areas, but you've not been designated as an expert for purposes of this trial. So don't take offense by my comments; they weren't intended in that fashion.

Mr. Sinclair.

BY MR. SINCLAIR:

Q. Let me change topics a little bit. You -- there has been discussions of risk arrangements in this trial so far. Have you had risk-based arrangement discussions with St. Luke's in your partnership with them?

A. Yes.

Q. And from your experience, does employment affect

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the ability to go to risk-based contracting?

A. Yes. And I have worked in several systems that have had various contract or employment or shared financial risk arrangements. And it's -- it's critically important when we talk about the change, when we talk about changing healthcare, one of the things that's very important is to align financial incentives. Because in our current healthcare system, which is largely fragmented and where it's basically every man for himself, if you will, every party is seeking to maximize their own personal benefit, whereas if you have employed physicians or highly affiliated physicians that are part of a larger system, then the entire system can work together.

And it goes back to in a system approach, where you have employed physicians with aligned financial incentives, then all of a sudden the rather perverse incentives that we have seen in today's fee-for-service system that's fragmented, all of a sudden everybody comes together in an integrated way and the value comes from keeping people healthy and really lowering costs. And that can both -- in my personal experience and in the literature -- be best accomplished through an integrated system; a system with employed physicians, and most importantly, the aligned financial incentives that tie right back into the culture of the organization.

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Q. So have you been able to reach your vision yet?
A. In -- are you asking about Utah or Idaho?
Q. Utah.
A. In Utah, we have made -- working as part of Intermountain Healthcare, have made tremendous strides. We have improved quality, we've improved access to care, we've managed to keep our health insurance premiums relatively stable. They are still not to the level that we would like. In fact, we have an aspirational goal within Intermountain Healthcare that we are on an active path to make sure that health insurance premiums in the future are more in line with the general consumer price index. Because we realize that, again, this trajectory where healthcare costs are three to four times the rate of the general inflation rate, again, is not sustainable, nor is it fair.

So we have very specific plans in place to reach CPI or CPI plus one goal. And the core -- the foundation of that work is the joint effort with the health plan, the hospitals, but relying very heavily on the employed medical group.

So we have set the structure, we've set the plan, we have a five-year plan. We are making progress, as I mentioned, on the quality, access and service. We are starting to make progress on the cost management to again achieve that Triple Aim goal of controlling per-capita cost.

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So I think we are well on our way toward that. And this is the same model that through all of our discussions with St. Luke's Health System over the past couple of years. We are aligned on that same model and path.

And even though we are not owned by St. Luke's, our goal is essentially to work with St. Luke's in the same fashion that we work with Intermountain.

Q. So have you reached your mission in Idaho yet?
A. Well, in Idaho, again, I -- I think we are off to a terrific start. And this took -- you know, it was a yearlong process to build the foundation. We have now been in operation for -- for almost a year. We essentially started marketing products and services that became effective in January. So now we have about eight -- eight months' worth of data. And what we are seeing here --

THE COURT: Could I -- when you say you have been in operation about a year, do you mean in Idaho --

THE WITNESS: Yes.

THE COURT: -- or in total? Just in Idaho?

THE WITNESS: Yes. In Idaho, yes. Thank you.

But at this point, we are -- we are on plan. We have set out a five-year plan. We are on plan, we're on budget, we're on track. We have built good systems for reporting and monitoring our clinical, financial, operational and

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strategic objectives. So I'm -- I'm pleased with where we are.

But it takes -- it takes years to build. And then it takes at least another year to have sufficient reporting to understand exactly where you are on these standardized metrics. So we are in this building process and we have to continue building, we have to have a critical mass of membership and we have to develop sufficient time to report our success on a valid number of members and claim data. So it takes time to both build and then it takes time to evaluate and report. But we are absolutely on track with our five-year plan.

BY MR. SINCLAIR:

Q. Can you explain to the court how and why SelectHealth decided to become aligned with St. Luke's?
A. Yes, I'd be happy to. It started out, as many things do, really through a personal relationship. I have mentioned I -- I am the CEO of SelectHealth. I report to our board of directors and I also report to the executive vice president of Intermountain Healthcare, and his name is Burt Zimmerly. Burt had previously worked with Dr. Pate when they were both working in Texas. So the two individuals knew each other.

And before I was involved in the conversations, my boss, Burt Zimmerly, had had conversations with Dr. David

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Pate about potential opportunities for Intermountain and St. Luke's Health System to do some things together.

And as I mentioned, this started out with a personal relationship, but it was also with the idea that these are two leading not-for-profit health systems closely adjacent in geography, and that in conversations they said there must be some ways we could do some things together to improve efficiency, to take advantage of certain functions. And the original discussion actually started between Burt, as I understand it, as Burt has relayed to me, between Burt and Dr. Pate about perhaps working together on supply chain purchasing because one of the major costs in healthcare is supply chain and equipment, and they thought that perhaps working together to improve purchasing and supply chain management would be a way for both organizations to actually help reduce the underlying cost of healthcare while maintaining quality. So the first discussion started around supply chain.

And then after that, there was this discussion about the success of Intermountain and how was that achieved and what role did the health plan play in that. And then shortly thereafter, a meeting was arranged with -- with Dr. Pate and others from his team, my boss, Burt Zimmerly, and myself to say, well, maybe there are some ways that we could work together in this integrated fashion, build on the

skills that SelectHealth had, build on the infrastructure that we had in place, maybe join forces and do what we do best in collaboration with St. Luke's Health System. And what it brought would be a ready-made lower-cost administrative infrastructure to combine with the clinical structure that St. Luke's had built, again, for the purpose of achieving the Triple Aim. And it was really because Burt knew -- knew Dr. Pate and knew the alignment of the vision and thought it would be a good fit. So we started having those discussions.

And then over a period of time, really developed a memorandum of understanding about our mutual objectives and then that turned into a definitive agreement and then we launched the products. So it all started with that first conversation.

Q. And from SelectHealth's perspective, are there any significant benefits from having Saltzer be directly affiliated and highly integrated with St. Luke's in Canyon County?

A. I think there is two: One, certainly from SelectHealth's perspective, it's very important to us to have a broad geographic coverage for a network because we basically, when we sell products in the marketplace, we are selling products and services and a network of physicians. And it's very important to have good geographic coverage

that is close to both where people work and where people live, because people tend to want to receive healthcare services close to their community. So that's a SelectHealth view per se.

The other view, and as I have really reflected on this, my understanding of the Saltzer clinic, and this comes, again, from my colleagues at St. Luke's, is that the Saltzer clinic --

MR. ETTINGER: Objection, Your Honor. Hearsay.

THE COURT: Sustained.

BY MR. SINCLAIR:

Q. Were you explaining why -- why SelectHealth believes there is a benefit of having the Saltzer physicians highly aligned with this program?

A. Yes.

Q. Are you testifying as to whether it's accurate or not as to your knowledge or whether this is the knowledge on which you base your belief?

A. This is my belief.

MR. ETTINGER: Your Honor, I guess -- I mean, the question is why is it relevant if only her belief?

THE COURT: That was the thought that came to my mind. Why is the witness's belief relevant? I think I allowed a lot more leeway, I think, with Dr. Pate because he was the decision-maker, and therefore, I thought his

mindset, his attitude, his understanding was all relevant, but I'm not sure Ms. Richards --

BY MR. SINCLAIR:

Q. Would that alignment of Saltzer be relevant to SelectHealth in attempting to reach its mission and vision in Idaho?

MR. ETTINGER: Your Honor, that gets back to the substantive question. That doesn't relate to whether her belief is relevant apart from the truth of the belief which is the only way this could be admissible. Mr. Sinclair just asked her, you know, how does it -- he just asked her the factual question --

MR. SINCLAIR: I just -- I am asking her what her belief was in regards to the importance of Saltzer -- or SelectHealth to reach its mission and vision in Idaho.

THE COURT: I guess the predicate to that argument, Mr. Sinclair, is that even though SelectHealth is not a party, that any overall economic benefit that they would reap in which they, through the integrated health care model that they described, could bring to the community would be a competitive -- an advantage that may justify what would otherwise be --

MR. SINCLAIR: Not only the financial aspect, but also the ability to improve the healthcare of the entire population.

THE COURT: Right. That's what I was alluding to. Maybe I didn't make myself clear.

I am going to overrule the objection and allow the witness to indicate her belief as to what is necessary for SelectHealth to bring their product into the market, both in terms of, as Mr. Sinclair pointed out, the bottom line for SelectHealth, but also for, I guess, the bottom line for healthcare in Idaho. You may go ahead.

THE WITNESS: Thank you.

THE COURT: And I guess you were just making -- identifying the second reason why you thought the full integration of Saltzer into St. Luke's was important to SelectHealth.

THE WITNESS: Yes. Thank you. It is about driving change. And when you go back to our vision, that last bullet point on our vision talks about being an active participant, a catalyst and an active participant in driving change. And in order to drive significant change, there's several elements required.

First, you have to have a common and aligned vision. And then you have to have common tools and methods. You have to make a significant investment in changing processes. And then you have to have the aligned financial incentives. All of these elements are necessary to drive change.

And as we talked about in some of these other examples,

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the -- the core of that change comes from a core group of physicians that share that same mission, that vision, they're financially aligned, and they have time to be able to change care processes. And that's why I believe having employed or affiliated physicians that are highly regarded in the community as a core to that change.

So it's fundamental to driving change. If you try to do things just by contract or contractors or vendors, that can be goods service, but it perpetuates a status quo.

To drive change, you need people that are fully aligned, fully committed, and willing to take and make the courageous types of changes that are necessary. So it is all about driving change.

And as I have seen that in my other work, change requires -- it's easier to have that culture of change when you have employed physicians with aligned incentives who can drive the change and create the foundation. So that's the broad reason for having employed and highly aligned physicians at the core.

And then, as I had mentioned previously, there is the practical day-to-day reasons of having adequate physician coverage to assure that you have access to a full range of physicians that are easily accessibility to customers.

BY MR. SINCLAIR:

Q. So those are the benefits to SelectHealth of

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having a highly aligned group like Saltzer in Canyon County?

A. Yes.

Q. Sort of a large global question: Why was it important to SelectHealth to become affiliated with St. Luke's?

A. The -- it was really interesting. We -- and we had a lot of internal discussions because it would be possible for SelectHealth to just have a contract with St. Luke's. We could have had a provider contract.

But we felt, for a number of reasons, that when we were coming into this market, we intended to be all in. And that means we intend to be here for the long term. We wanted to align ourselves with a highly regarded system. It was important that the system be not for profit. It was important that the hospital system also have alignment and affiliation with physicians.

So for all of those reasons -- and it -- and it really went back. It was clearly the mission, vision, and values, but it was also what St. Luke's brought to the table with recognition and preference, the alignment that they had built with physicians. And then most importantly, we said we want to build a strategic affiliation and that affiliation, and when you look at our -- our principles of that affiliation, it was to bring benefit to the communities in Idaho. And we shared that. And it was to help stabilize

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cost for purchasers in Idaho. And it was to improve the health of the community and we felt through working with this long-term strategic affiliation, there would be no doubt about our long-term commitment.

And then we also do many things in the community jointly. And again, whether it's health promotion -- or I think it was just about two weeks ago we jointly were sponsors of the FitOne initiative in Boise. And our team was there helping people understand health reform and the new exchanges and how that would affect them. And we were working side by side with the St. Luke's team who was there doing health screenings, blood pressure checks, again, really trying to promote health. So part of our affiliation is also the comarketing and cobranding and conjoined efforts in the community to improve health.

So that's why we -- we knew we were all in, we made the commitment for the long term, and it's not a contract that we are willing to just walk away from if it didn't work well in the first year or two.

MR. SINCLAIR: Your Honor, my next area is attorney's eyes only, looking at the time, I'm thinking it might be good time for a break.

THE COURT: You read my mind.

MR. SINCLAIR: And I'm going to see if I can get around the attorney's eyes only during the break and avoid

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that.

THE COURT: All right. Let's -- we will take the break.

Counsel, one -- well, I'll wait. I do have a couple of questions I'm going to ask the witness. I will wait until direct and cross before I ask it and then you can follow up on my questions. The reason I do that, I don't want to jump in with both feet only to find out you are going to cover it with your direct or your cross but I do have some questions here.

I just noted, I don't think this is clearly not an issue in the case at all, but I do, you know, the aforementioned health issue, my otolaryngologist, I have one here with Southwest Idaho Ear, Nose and Throat, which is near Saint Al's facility, I don't know if they're affiliated or not, and I also go to a Dr. Scheulle at McKay-Dee and I suspect -- I think that's an IHC facility, but I'm not sure of that. Would you know?

THE WITNESS: McKay-Dee Hospital is an Intermountain hospital.

THE COURT: All right. I -- I think it is completely irrelevant, except that I thought I might as well point it out. If you think it's relevant or of concern, you can file a motion to recuse me and get another judge and start the trial over. All right.

We will be in recess.
(Recess.)
****** COURTROOM CLOSED TO THE PUBLIC ******
THE COURT: Thank you. Please be seated.
For the record, I will remind the witness, Ms. Richards, you are still under oath.
Mr. Sinclair, you may resume your direct examination.
MR. SINCLAIR: Thank you, Your Honor. I totally failed avoiding the AEO. So we will need anyone not connected with SelectHealth or an attorney to leave the courtroom.
THE COURT: The only ones allowed to remain would be those connected with SelectHealth; correct?
MR. SINCLAIR: And trial counsel.
THE COURT: And what?
MR. SINCLAIR: And trial counsel.
THE COURT: Obviously. It would be kind of a lonely trial.
MR. SINCLAIR: Maybe we could have Mr. Ettinger excluded. (Laughter.)
THE COURT: Go ahead. Are we going to be showing any exhibits?
MR. SINCLAIR: No.
THE COURT: Otherwise, we'd close the screen and put it over the glass. But if we're not showing exhibits,

that shouldn't be a problem.
MR. SINCLAIR: Ready?
THE COURT: Yes.
BY MR. SINCLAIR:
Q. Ms. Richards, there are allegations in this trial so far that part of the motivation of St. Luke's in its endeavors with Saltzer is to grow its market share in order to increase pricing. Were there any discussions between SelectHealth and St. Luke's in regards to growing market share?
A. No. The only discussions were how to have good products and services in the marketplace and how to achieve our joint goal of actually reducing the cost of healthcare services.
Q. From SelectHealth's perspective, you want as many insureds as you can so you have viable product; correct?
A. Correct.
Q. Was there any discussion about increasing the prices by the collaboration you were doing?
A. No, not at all.
Q. Has -- to your knowledge, has SelectHealth coming into the Idaho market any effect upon pricing in Idaho for insurance products?
A. Yes. You know, one of our goals was to bring competitive pricing and have very predictable premium

increases going forward. And we thought we could bring a meaningful competition to the marketplace.
And while we are on our plan in terms of growth, one of the -- I guess it is an unanticipated side effect, if you will -- we actually believe we were maybe more successful in bringing more competition to the marketplace because just our sheer presence in the marketplace has basically caused other insurers in the market to sharpen their pencil in terms of premiums for customers.
So even though we did not get some of the customers, some of the customers where we offered competitive insurance quotes actually benefitted tremendously by having their current carriers come back and reduce their prices -- premiums sometimes multiple times.
So it's kind of an odd way to achieve the goal of making healthcare more affordable in the region, but just our mere presence has actually helped certain purchasers have more competitive premiums that were offered than through other carriers in direct response to our offering a competitive quote.
Q. So you made a quote, and it was your understanding your quote was lower than some of your competitors?
A. Yes. You know, in fact, I mentioned in the -- one of our missions is to provide healthcare cost -- healthcare at the lowest appropriate cost.

And one of the things that we believe sets SelectHealth apart, we try to be very open and transparent about how we develop our premium pricing, and we try to not play some games with the pricing. We do not go in and offer a high quote and then reduce it and things like that. We try to offer the right quote initially that is built on the underlying cost that we anticipate for the services and built around the population of the people -- age and sex and health conditions -- that will be insured.
So we basically try to always hit the right premium the first time, the right time. So we offered in many cases -- and I track -- I work with our general manager, and I monitor sales reports, sales activity, and the outcome of quotes.
As we would offer very competitive quotes that typically the insurance broker or the customer would be very pleased to receive -- they would say, "Wow, this is great" -- but then their existing carrier would turn around and come back, and they may have offered a 10- or 15- or 20-percent rate increase. We offered a competitive quote, and then the original carrier would come back and, quote, knock off a few percentage points; they would come in with a quote that was lower than ours, either by a few points or a substantial margin, to keep the business.
So -- so the other carriers adjusted their quotes

after employers received quotes from us. The net impact was that it really benefited the employer or the purchaser. It also allowed the incumbent carrier to keep the business. And that wasn't in certainly every case, but we have many, many examples where our -- what we thought was an accurate quote was underbid.

So that is why I say it has sort of achieved the results of making healthcare more affordable in the community, but it was not necessarily the way we set out to do it.

MR. SINCLAIR: Your Honor, that's all I have.

THE COURT: Mr. Ettinger or who is --

MR. SINCLAIR: Can we open the courtroom again?

THE COURT: Yes.

****** COURTROOM OPEN TO THE PUBLIC ******

THE COURT: Mr. Su, you are going to do the cross?

MR. ETTINGER: Your Honor, we both may, but he can start.

THE COURT: All right. Mr. Powers and Mr. Wilson, I don't mean to exclude you. I assume you have arranged a cue, if there is one, to line up and cross-examine the witness.

MR. POWERS: We have, Your Honor. We divided the witnesses.

MR. SU: May I proceed, Your Honor?

THE COURT: Yes, you may.

CROSS-EXAMINATION

BY MR. SU:

Q. Ms. Richards, Mr. Sinclair asked you about the relevance of having Saltzer to SelectHealth and its affiliation with St. Luke's. Isn't it true, in your experience, when building a provider network, it is important to have primary care physicians close to where the members live?

A. Yes.

Q. And, in fact, if a health plan doesn't have primary care physicians close to where its members live, then that network would not be attractive to its members; right?

A. Yes. It is important both where they live and where they work.

Q. And it is your position that, then, SelectHealth needs Saltzer in its provider network because you want a robust provider network that would be attractive in the commercial market?

A. Yes.

Q. And from your experience with past plans, you know that consumers like very much and they value having primary care physicians close to home?

A. Yes. Again, close to both home and work, easily

accessible.

Q. Your testimony when you gave a deposition in this case was that it was close to home, within a few miles, ten to five minutes of home; right?

A. Home and also accessible from work.

MR. SU: May I have Mr. Beilein play clip 7. And this will be from the deposition of Ms. Richards, page 156, line 5 -- line 25 to page 157, line 20.

THE COURT: We have not yet published Ms. Richards' deposition; correct?

MR. SU: We have not, Your Honor.

THE COURT: If you would provide the original, I will have Ms. Gearhart publish the deposition at the conclusion of the examination.

MR. SU: Yes, we will do that.

(Video clip played as follows:)

Q. "... time and distance requirements that are in place for primary care physicians in order for you to be awarded that contract?

A. "The -- I honestly don't remember exactly because I'm not that close to the work. It is usually -- my recollection is we're talking 30 minutes. I believe that's the regulatory requirement. It might be 20 minutes. It might be a 20-minute, but it's very close. And

that's to meet the minimum regulatory standards.

"And then also, in addition to meeting the regulatory standards, you have to meet the market acceptability standards; in other words, what do consumers want. And my experience with past plans is that consumers would like very much and they value having their primary care physician close to home, within a few miles, 10 to 15 minutes.

"So there's a kind of a market acceptability that we are trying to achieve, and we also have to meet the minimum regulatory standards."

(Video clip concluded.)

BY MR. SU:

Q. Ms. Richards, that is your testimony that you gave under oath in the deposition?

A. Yes.

Q. And your words were "having their primary physician close to home, within a few miles, 10 to 5 *[sic]* minutes"; correct?

A. Yes, although it is not my complete testimony.

Q. Yes or no, that is your testimony?

A. That is my testimony, but there is additional

testimony.

THE COURT: Mr. Sinclair will give you a chance to go into that, if need be.

THE WITNESS: Okay.

THE COURT: Go ahead, Mr. Su.

BY MR. SU:

Q. You know that Saltzer Medical Group is in the BrightPath Network, correct?

A. That is my understanding, yes.

Q. And the BrightPath Network is a provider network that SelectHealth is using for the new products that it is offering in the state; is that right?

A. We are using the BrightPath Network, and then the physicians have an opportunity to accept or reject to participate and serve the SelectHealth plans. So there is a messenger model associated with it.

So we base it on the BrightPath Network, but it doesn't include necessarily 100 percent of the BrightPath providers.

Q. But whatever the BrightPath Network provides in terms of physicians is what you are getting for your products?

A. As long as the individual physician also signed an addendum to participate in SelectHealth, yes.

Q. Also, in response to Mr. Sinclair's questions, you

talked about specific benefits, other benefits from the St. Luke's affiliation with Saltzer; right?

A. (No audible response.)

Q. You recall, don't you, that when asked this very question in your deposition, you said you do not have any personal knowledge of those specific benefits; correct?

A. That's correct.

Q. And, in fact, you recall also that you submitted a declaration to the Court back in December of 2012?

A. Um-hmm.

THE COURT: You need to answer yes or no.

THE WITNESS: Oh. Yes.

THE COURT: Thank you.

BY MR. SU:

Q. And when you were asked about that declaration during your deposition, you said you had not had a specific discussion with St. Luke's about, quote, "any significant benefits from having Saltzer be directly affiliated and highly integrated with St. Luke's"; right?

A. That's correct.

Q. So all you were expressing was just your personal belief that, in general, employment or highly affiliated group practices can lead to significant value; right?

A. Yes.

Q. So you weren't talking specifically about any

value that might flow specifically from St. Luke's acquisition of Saltzer?

A. Correct.

Q. Also, during your deposition, you told my colleague, Mr. Litvack, you had never had any conversations with any Saltzer physician about the benefits of the acquisition; correct?

A. That's correct.

Q. Now, you were also asked in your deposition about --

MR. SINCLAIR: Your Honor, I am going to object to this line of questioning. This is not a party. Her deposition can be used for impeachment, but it can't be used for direct and redirect.

THE COURT: I think that's correct. Mr. Su, you can ask the question of the witness. If she gives the same response she did in her deposition, we will accept that here; if she didn't, you can use the deposition for impeachment.

MR. SU: I will do that. Thank you, Your Honor.

BY MR. SU:

Q. Now, when you use the term "directly affiliated," as you did in your December 2012 declaration, you don't mean that a physician group necessarily has to be employed or owned by a health system; correct?

A. Correct.

Q. In fact, what you mean by "directly affiliated" is that there just has to be a close working relationship between the physician group and the health system; correct?

A. What I mean is there has to be a highly aligned relationship that shares those common commitments and values and visions that I discussed earlier in my testimony today.

Q. Right. So what is important here, as you've testified, is the culture, is the shared vision between the physicians on the one hand and the health system?

A. Yes.

Q. And so that would include working together through the physicians having privileges at the hospital; right?

A. That would be a minimum requirement. As I also mentioned, it requires aligned financial incentives. It requires time and ability to spend time working on developing clinical protocols and implementing those clinical protocols. It also involves assuming a leadership role.

So there is a lot when you talk about -- or when I talk about a highly aligned or affiliated relationship, it is a significant relationship.

Q. A close working relationship is what you said; correct?

A. Um-hmm.

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Q. Is that correct?
A. **Yes. I'm sorry.**
Q. And your point about financial alignment, that is just to get -- to ensure that there is this common shared vision; correct?
A. **It is one of the required elements, yes.**
Q. It is a means to an end?
A. **Um-hmm. Yes.**
Q. And, in fact, SelectHealth in Utah has been able to forge close working relationships with independent physician groups; correct?
A. **That is correct.**
Q. Like the Central Utah Clinic, as an example?
A. **Yes.**
Q. And that was a multispecialty physician group?
A. **Yes.**
Q. Now --
A. **That was not an original -- that isn't where things started, though. Even within Utah, things started with the core of the employed physicians, and that -- having that core of employed physicians allowed for the development of many of the clinical programs. And that was the starting point.**

And after those had begun to mature, then we were able to bring in other physicians who could also then

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participate on the work that -- the foundational work that had already been done.

And when we pilot new programs to either improve quality or align physician incentives, we often start with our employed physician group because that is the most closely aligned arrangement that we have.
Q. Yes. But my question was: Central Utah Clinic was not part of this core group?
A. **Correct.**
Q. It was an independent physician group?
A. **That was added at a later date, yes, after the foundation had been built.**
Q. Right. So if St. Luke's already has a core group, it can work with Saltzer as an independent medical group; correct?
A. **I don't know the extent. I don't know how full that core group is, in all honesty.**
Q. And you don't know whether St. Luke's acquisition of Saltzer creates the proper aligned incentives between that group and the health system, do you?
A. **I believe it sets the framework, it sets the opportunity for those aligned incentives.**
Q. Now, Mr. Sinclair asked you some questions about risk-based contracting.
A. **Yes.**

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Q. In Utah, SelectHealth currently doesn't have risk-based contracting in any of its commercial plans; correct?
A. **There is some risk-based contracting in a very small network.**

SelectHealth has three different networks. We have the Value Network, which is built primarily around the employed medical group. Then we have a larger network called the Med Network. And our largest network is called the Care Network, which is a very broad network, essentially an any-willing-provider network that includes, for instance, the University of Utah.

So we have very small, medium, and large networks. The smallest network, the Select Value Network that is built around the Intermountain Medical Group, is a risk-based network in our commercial product.
Q. Now, you were asked about the -- to tell the history of Intermountain Healthcare.
A. **Yes.**
Q. And you believe that the lessons that Intermountain has learned from its own experience help inform your views about what is achievable; correct?
A. **Yes.**
Q. And do you know who Dr. Brent James is?
A. **Yes.**

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Q. He's the chief quality officer at Intermountain?
A. **Yes.**
Q. You have talked to him?
A. **Yes.**
Q. You have talked to him about his views, about his experiences with Intermountain?
A. **I've talked to him in that I have taken his training program, the advanced training program for professionals. I don't know that -- and I have heard him lecture many times. I don't know that I have actually had a personal conversation with him about his views about Intermountain other than, as I said, I have taken his course, and I meet with him periodically.**
Q. So you have taken his course. You look to him as a teacher?
A. **Yes.**
Q. You value his opinions?
A. **Yes.**
Q. All right. Let me show you what we'll call Cross Exhibit 3040. If you will put that up. If you will go to, first of all, to the second page, Mr. Beilein.

Do you recognize this article, Ms. Richards?
A. **I recognize the title. The text is not -- I can't get a clear view on the screen. It is a little too small for me to read.**

Q. Maybe we could just highlight the abstract -- actually, we have a hard copy as well. With the Court's leave, Mr. Oxford will provide it to Mr. Metcalf.

MR. SINCLAIR: Do you have a copy for me?

MR. SU: Yes, sir. Right here.

THE WITNESS: Thank you.

BY MR. SU:

Q. Ms. Richards, is the paper copy better?

A. Yes. Thank you.

Q. All right. Great. So you said you recognized the title; is that what you said?

A. Yes.

Q. And you recognize the authors?

A. Yes.

Q. They are both employees of Intermountain, aren't they?

A. Yes.

Q. And one of them is Dr. James?

A. Yes.

Q. Now, I would like to direct your attention to page -- the article itself has its own numbering, and we are looking at page 1189. Do you see that?

A. Yes.

Q. Do you have that page?

A. Yes.

Q. Specifically on the left-hand column on that page, I wanted to direct your attention to the text that begins with the subheading "Improving clinical care by reorganizing its delivery."

A. Yes.

Q. And I will read the text. It says, "The majority of the physicians involved in executing Intermountain's key clinical processes are independent, community-based practitioners. This protected Intermountain from a classic blunder: We didn't try to control physicians' practice behavior by top-down command and control through an employment relationship. Instead, we relied on solid process and outcome data, professional values that focused on patients' needs, and a shared culture of high quality."

Do you see that?

A. Yes.

Q. Do you agree with what Dr. James has said -- has written in that paragraph?

A. I would agree that, at this point, a lot of the execution is done by independent physicians; and yet, at the same time, about 25 percent of the physicians who practice at the Intermountain facilities are employed physicians.

And I believe that what Dr. James is speaking about especially is that this is physician-led change as opposed to administrator-led change.

So he believes that the changes have to arise from good clinical evidence, and they have to be championed by respected colleagues. And in conversations that I have had with Dr. James, he doesn't believe that is possible for a health plan by itself, for instance, to set protocols and then impose them on physicians; nor does he believe that hospital administrators should set the protocols and impose them on physicians.

He believes -- and we've had these discussions -- that it should be based on the best clinical evidence, and then that evidence should be turned into work processes that support the physicians. So it is really led by the profession.

I can't comment and I have never had a discussion with Dr. James about the command and control through an employment relationship. So I cannot make a comment about that.

Q. In your experience, physicians like autonomy, don't they?

A. Historically, yes, physicians have liked autonomy, and it has been kind of a cottage industry. But what we are finding --

Q. Yes or no?

A. Yes.

Q. Mr. Sinclair asked you some questions about the

strategic affiliation agreement with St. Luke's.

A. Yes.

Q. That agreement provides that -- it has a potential gain-sharing component; correct?

A. Yes.

Q. And that gain-sharing component, if you were to realize a net surplus of dollars, that would go to both St. Luke's providers and facilities and non-St. Luke's independent providers and facilities; correct?

A. Yes.

MR. SU: That's all I have. Mr. Ettinger may have some other questions.

THE COURT: Mr. Ettinger.

CROSS-EXAMINATION

BY MR. ETTINGER:

Q. Ms. Richards, it is your view that the BrightPath Network provides good access for physicians to SelectHealth; is that correct?

A. Yes.

Q. And it is your view that the BrightPath Network has demonstrated a commitment to evidence-based medicine that is aligned with SelectHealth's goals; correct?

A. Yes. They have -- it's maybe not the complete answer, but yes.

Q. That was a -- and, in fact, the vast majority of

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physicians in the BrightPath Network, almost 90 percent, are independent physicians; correct?
A. I don't know the specific ratio.
Q. Do you know the approximate ratio?
A. No, I do not.
Q. Now, in Utah, the broader networks you referred to are Select Choice and Select Care; correct?
A. I have referred to Select Care and Select Med.
Q. And both of those are -- the vast majority of the physicians in that network are independent; correct?
A. In Utah --
Q. Is that correct?
A. It depends how you define "vast majority."
Q. More than 75 percent.
A. It is very close. I would say we have a core of about 30 percent employed and the remaining independent; but, again, I don't know the exact percentage off the top of my head.
Q. Now, Mr. Su asked you some questions about direct affiliation. In fact, it is your view that an independent physician group could be directly affiliated with a health system within the meaning of "directly affiliated" as you use that term, correct?
A. They could be affiliated, yes.
Q. And just to be clear, you have not been to

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Saltzer, you have never talked to anybody from Saltzer?
A. I met the president of Saltzer today.
Q. Not until today?
A. Correct.
Q. You are not -- with the one exception you mentioned, you are not aware of when, if ever, SelectHealth will implement risk-based contracts for commercial plans in Utah; correct?
A. No, that is not correct.
MR. ETTINGER: Could we play Richards Cross 3, Your Honor? This is Ms. Richards' deposition.
THE COURT: Could you give me a page and line?
MR. ETTINGER: Yes. This is page 38, lines 22 through 25.
THE COURT: Thank you.
(Video clip played as follows:)
Q. "Do you know when SelectHealth plans to implement risk-based contracts for commercial plans it offers?"
A. "No."
BY MR. ETTINGER:
Q. Was that your testimony?
A. That was my testimony as of June.
Q. Thank you.
A. I am now aware --

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THE COURT: Mr. Sinclair will give you a chance to explain that.
THE WITNESS: All right. Thank you.
BY MR. ETTINGER:
Q. And, in fact, it is your view that fee-for-service payments will always be a component of the SelectHealth-St. Luke's arrangement, and it's unrealistic to expect fee-for-service will go away; is that right?
A. Yes.
Q. Are pediatricians in all of the networks offered by SelectHealth?
A. Yes, to the best of my knowledge.
Q. You would not offer a network without pediatricians, would you?
A. I can't imagine that we would.
Q. And as of now, there is no agreement as to how St. Luke's will participate in trying to get quality improvements in the SelectHealth relationship; correct?
A. There is teams working on that.
Q. There's no actual agreement today as to how that will work; correct?
A. The mechanics are not defined today; correct.
Q. And any value-based payments between SelectHealth and St. Luke's will not occur until at least year 3 of the contract; isn't that right?

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A. That's correct.
Q. And St. Luke's doesn't have the capacity to handle full risk today; correct?
A. I don't believe that St. Luke's or BrightPath have that capacity built yet.
Q. And, in fact, isn't it the case that when you were talking to St. Luke's, you originally started out talking about a full-risk percent-of-premium approach, and St. Luke's chose to move away from that because it began to understand what that involved and concluded that it wasn't ready for full risk; correct?
A. Correct.
Q. If Saltzer were not owned by St. Luke's and were available to SelectHealth in the BrightPath Network and were also available -- and was also available to competing payors and competing networks, do you think that would be unfair competition in any way?
A. One, it is a hypothetical question; and, two, it is a question that I'm not really qualified to answer.
MR. ETTINGER: Thank you very much.
THE COURT: Mr. Sinclair, let me ask just a couple of questions, and then you can follow up with my questions in just a moment.
EXAMINATION
BY THE COURT:

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Q. Ms. Richards, I think the primary question I had was already asked by Mr. Su and Mr. Ettinger. At this point in time, SelectHealth, in terms of your insurance product it is offering, is essentially a traditional fee-for-service policy, or how does it vary from, say, what Blue Cross of Idaho or Regence Blue Shield or any of the other insurance companies -- how is it any different?

A. It is similar, of course, in terms of rates and benefits in network and offering competitive pricing. The payment arrangement at this point is primarily fee-for-service because we are in this very early stage of development. We have small numbers of members, and we don't have sufficient experience or claim history or data to really move into a risk-bearing arrangement.

So the reason that it is more traditional fee-for-service is because it is so new. We do have some level of risk-bearing arrangement in our Medicare Advantage product. But that's correct.

Q. How long has it been functioning in Utah, SelectHealth?

A. It has been functioning in Utah since 1984. So I guess about 30 years almost.

Q. I guess the somewhat obvious question, then, is: Despite that 30-year experience, that has not been sufficient time to develop claim experience data and

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statistics that would allow you then to bring out a risk-based product? What is it that's keeping you from doing that, say, in Utah?

A. Oh, in Utah. What would be keeping us from doing that has really been management and leadership decisions of the Intermountain Healthcare system. For many years, the health plan, while it was a wholly-owned subsidiary, it was really kind of off to the side as a more independent organization that was not fully integrated with the delivery system. And so it was really just seen almost as an independent enterprise.

Whereas now, and over the last three to four years, there has been a concerted effort to integrate and coordinate services between the health plan and the delivery system. And, in fact, we are on a path now to create a fully integrated population health management system, and we have --

Q. And that would be a risk-based product?

A. And that would be risk-based.

And, in fact, this year, one of the key points where we started the risk-based financial arrangement with Intermountain, the system is at full financial risk for the Medicare Advantage product that we offered in January, the full financial risk for the managed Medicaid product that we offered in January.

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As I said, it has really been -- it was a management leadership decision of Intermountain for a long time to treat SelectHealth separately. But now, with recognizing the direction that is necessary to create sustainable cost, we at Intermountain have moved towards something we are calling "shared accountability."

So we have absolutely integrated and coordinated our work efforts because of the entire system. Our board, the Intermountain board, has developed the belief that the only way -- the only type of sustainable system for the future is one that is highly aligned, highly integrated, highly coordinated with those shared risks.

Q. So if I'm understanding you, then, you are saying this was a decision made by IHC, say -- well, a decision made quite some time ago but implemented in the last three to four years, and that is the actual experience you have to which you could kind of analyze what the premiums would look like, what the structure would look like, and how you would share the risk?

A. Yes.

Q. Now, is --

A. There is one point, if I could add.

Q. Go ahead.

A. Because SelectHealth is a wholly-owned subsidiary, our financial results roll up, and they are consolidated

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with the parent company. So it is also logical to say that the parent company has, in fact, been at risk for SelectHealth performance since its inception. So they have been at financial risk, but it has only been the last few years where we have really taken on the risk for population health and with this emphasis on health improvement and really expanding on these clinical programs.

Q. It is a wholly-owned subsidiary of IHC, which is a not-for-profit?

A. Correct.

Q. How -- so if a patient, or more likely an employer, were to contract with SelectHealth, there would be a flat-rate charge per capita --

A. Yes.

Q. -- for all people enrolled without variation -- of course, under the Affordable Care Act, there's no preexisting condition, presumably in any event.

And the consequence of that would be there would be -- would there still be deductibles? I am assuming those would be intended to maybe influence behavior by the patient to encourage them towards healthy conduct, not towards discouraging them from obtaining healthcare?

A. Correct, yes.

THE COURT: Well, Counsel, I think -- I guess it would be helpful for me to have a better sense -- and maybe

before the end of the next two weeks, I will have that -- as to precisely what that risk-based system would look like from a consumer's point of view. And I think I am getting a glimmering of it, but it may be helpful as we move on.

Mr. Sinclair, redirect.

MR. SINCLAIR: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. SINCLAIR:

Q. Mr. Su asked you some questions about having primary care physicians close to home. Do you remember that?

A. Yes.

Q. And you indicated there was more in your deposition than what he had referenced; is that correct?

A. Yes.

Q. Looking at page 182 of your deposition, which is on the screen, was this also your testimony that day?

A. Yes.

Q. So your answer was: It could include where someone works. Typically, in the Medicare population, most people are retired, and it's close to home for Medicare Advantage enrollees.

But for the commercial population, many of whom are employed, it's really both family and dependents. It's important both close to home, but where someone is working,

it's very important that they also have access to care that's very close to their workplace. So it's really about ease access -- easy and convenient access and availability."

That was your full answer; correct?

A. Yes.

Q. And that is what you were trying to explain to Mr. Su?

A. Yes.

Q. Can we flip over to the document camera.

This is the page that Mr. Su used out of the exhibit. I don't remember the number of it. It is the article that he referenced, Mr. James.

I guess now you can indicate, since they put this before you, whether Intermountain has had any success in the initiatives it has introduced since 1995.

A. Yes, I believe there has been many examples of success.

Q. This says --

MR. SU: Objection. We just used this as an impeachment exhibit.

MR. SINCLAIR: I don't know how you impeach somebody with a document written by someone else.

THE COURT: Well, the witness had indicated that the model for SelectHealth was based upon IHC's approach. And I think the impeachment --

MR. SU: The impeachment, Your Honor, is that the witness expressed a view that, you know, IHC has an employment-based model, and the impeachment was Dr. James' own opinion about the disadvantages of employment.

THE COURT: I don't know that it is impeachment in the sense of showing a prior inconsistent statement. I think it was offered, really, just as a cross-examination document.

Are you offering the exhibit?

MR. SINCLAIR: Sure.

THE COURT: Is there any objection? It apparently is marked as a plaintiffs' exhibit.

MR. SU: It was marked as a cross-examination exhibit, which is why it had been assigned a 3000 number, Your Honor. We had not intended to offer it as a substantive exhibit.

THE COURT: Mr. Ettinger?

MR. ETTINGER: I would object that it's hearsay, Your Honor. I would object to it as a substantive exhibit.

MR. SINCLAIR: Then I would move to strike the apparent attempt to impeach on a statement that is not this witness's statement.

MR. ETTINGER: It is somebody who she took courses from, she learned from, she studied from, Your Honor. He's effectively her mentor.

MR. SINCLAIR: Well, that could make the Court's statement impeachable against most of the bar in the state of Idaho.

THE COURT: Counsel, I think I either need to consider the entire statement, what Dr. James was saying or not saying, or not at all, because it is not this witness's statement.

I think it is fair to raise it on cross-examination because I understood the linkage between her testimony that SelectHealth was based upon the fundamental underlying principles adopted by IHC. And then this statement included by Dr. James indicated they, in fact, were opposed to the kind of close vertical alignment that was being undertaken here.

I understood the point, but I think I need to see the entire statement by Dr. James so I can put it in context or not at all, unlike what I would do if this were a statement by Ms. Richards and she were impeached on that.

So you have your choice. I'm either going to strike it, or I'm going to review the entire document.

MR. ETTINGER: Can we have 30 seconds?

THE COURT: You may.

MR. SINCLAIR: On their time?

THE COURT: I'll be magnanimous and not charge the time to anyone.

MR. ETTINGER: Your Honor, I will withdraw my objection.

THE COURT: The exhibit will be considered and admitted.

MS. DUKE: Yes, Your Honor.

THE COURT: All right. And that's Exhibit 3 --

MR. SU: 3050.

THE COURT: Now it's going to get really confusing because now I'm admitting 3050.

MR. SU: I'm sorry. 3040.

THE COURT: 3040.

(Plaintiffs' Exhibit No. 3040 admitted.)

BY MR. SINCLAIR:

Q. The article also indicates that there has been a $50 million cost reduction in one year in Utah as a result of the labor induction protocol it interposed; correct?

A. Yes.

Q. These are the types of things that are fulfilling the vision and the mission of SelectHealth and Intermountain Health?

A. Yes. If I could add --

Q. Yes.

A. Kind of the rest of the story is a lot of the Intermountain work is built around these clinical programs that I mentioned that have been in place for about the last

ten years. And the clinical programs work with physicians to build the best clinical evidence and then build it into the work processes and the work flows and the policies and procedures of the organization.

This particular savings comes out of what is called the maternal and fetal women's and newborns' clinical program. And the lead physicians in the women's and newborns' clinical program are, in fact, employed physicians through the medical group.

So they do the leadership. They do the change management. They develop the protocols. Then they get input from other practicing physicians, and then they work with Intermountain to set up the infrastructure to deploy the programs.

So while the independent physicians are certainly welcome to participate, it goes back to the leadership, and the origin started with the physicians who are full-time employees who have the time to develop new ways of delivering care to achieve these results.

So it is absolutely true this particular protocol is now widely accepted, but it really started with the work of the employed physicians in the women's and newborns' clinical program.

Q. Thank you. And you may have addressed this in your discussions with Judge Winmill, but when Mr. Ettinger

was asking you about risk-based and whether SelectHealth will implement risk-based contracting in commercial plans in Utah, you were cut off and you were going to say something else. Did we cover that, or is there more?

A. Thank you. I would like to add: In June, at the time of the deposition, we did not have a schedule planned for when Intermountain would begin to assume more financial risk in the commercial market.

As I said, they are accepting financial risk now under a full-risk arrangement for Medicare and Medicaid, but we are going through this planning and development and refinement process.

And as of -- just in the past couple of weeks, we have determined that we will be ready to move our commercial products, our large employer commercial products -- it is now in our work plan and schedule that we will be quoting these premium rates at CPI plus one in 2015 for implementation in 2016.

And what we are targeting right now is, at the same time, we will be taking our large employer population, and that will become a full-risk-sharing arrangement with Intermountain beginning, we anticipate at this time in our plans, mid 2015, more implementation in 2016, and then probably full implementation by 2017.

And so while I did not have a timetable in June,

we now have a timetable for a stepped approach to expand risk sharing to our large employers.

Q. There was another question which I thought you wanted to follow up on, and that was teams working on quality improvement with St. Luke's.

A. Yes. I forget the exact question, but it was about what have we implemented, I think, so far.

What we have, as part of our affiliation, we set up a number of work teams. And one of the work teams is on clinical alignment. And under that clinical alignment team, we have physicians and leaders from SelectHealth working with physicians and leaders from St. Luke's on a number of clinical programs where we are trying to align our clinical protocols around pharmacy, around quality, around utilization and care management, and around incentives.

So we have that active work going on to, again, build -- and it goes back to the triple aim. We are trying to build protocols around preventative care, chronic care management, maternal care management, pharmaceutical management. And we are making very good progress.

We have joint work on pharmacy and therapeutics teams. We have joint work on medical technology assessment teams. We have joint work being done on the customer satisfaction and the quality improvement teams.

And as these decisions are made by leaders, then

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they are shared with the rest of the clinical leadership group and other affiliated physicians so that they can be rolled out and deployed.

But each of these change mechanisms requires work, a lot of work -- a lot of building trust, building relationships, looking at data, then determining policies, getting those policies ratified, then building the infrastructure to support them.

So, once again, we are well on track because we don't -- we really believe it is going to take at least -- it will be year three of our affiliation before we will start to see some of the very specific metrics that I referred to earlier with the CAHPS and HEDIS, because it takes time to build; then you have to collect data; then you have to evaluate data.

So we are on the right path, but it doesn't happen overnight.

Q. Thank you.

MR. SINCLAIR: One correction for the record, Your Honor. When we were watching the clip on page 157 of her deposition, at line 17, it said in the transcript "10 to 5 minutes." And I believe, if you listen to the actual transcript, it says "10 to 15 minutes."

THE COURT: Counsel, do you disagree?

MS. DUKE: We agree, Your Honor.

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THE COURT: Then we will make that modification in the transcript.

MR. SINCLAIR: That's all I have, Your Honor.

THE COURT: Any recross?

MR. SU: No, Your Honor.

MR. ETTINGER: No, Your Honor.

THE COURT: You may step down, Ms. Richards. Thank you.

THE WITNESS: Thank you very much.

THE COURT: Call your next witness.

MR. BIERIG: Your Honor, we would call Director William Deal of the Idaho Department of Insurance.

MR. SINCLAIR: While Mr. Deal is coming in, I would move the admission -- although I don't think you'd move admission -- of the demonstrative exhibits I have used.

THE COURT: No. I think as long as we have noted them for the record, and then I will direct counsel to submit all of those to the Court so we have a record that can go up on appeal, if need be.

Sir, would you please step before the clerk, Ms. Gearhart, be sworn as a witness, and then follow her directions from there.

WILLIAM WALLACE DEAL,

having been first duly sworn to tell the truth, was examined and testified as follows:

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THE CLERK: Please state your complete name and spell your last name for the record.

THE WITNESS: My complete name is William Wallace Deal. W-I-L-L-I-A-M, second name Wallace, W-A-L-L-A-C-E, last name Deal, D-E-A-L.

THE COURT: You may inquire of the witness.

MR. BIERIG: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. BIERIG:

Q. Good afternoon, Mr. Deal. It is nice to see you again.

A. Good afternoon.

Q. Are you employed by the State of Idaho?

A. Yes, sir.

Q. And what is your position with the State of Idaho?

A. I am the director of the Department of Insurance for Idaho.

Q. For how long have you been the director of the Department of Insurance?

A. About six-and-two-thirds years.

Q. In that position, you are the highest-ranking official in the state of Idaho in the field of insurance?

A. I am the director of insurance, yes.

Q. And is there another agency that is higher than yours in terms of directing -- in terms of regulating

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insurance in the state of Idaho?

A. No.

Q. Before you became director of the Idaho Department of Insurance, what business were you in?

A. I was in the insurance business. I had my own agency.

Q. What was the name of that agency?

A. W.W. Deal Insurance Agency.

Q. And where was that agency located?

A. In Nampa, Idaho.

Q. Did the agency sell health insurance?

A. Yes, it did.

Q. Were you involved in the selling of that insurance?

A. Yes, I was.

Q. And based on your experience running the W.W. Deal Insurance Agency in Nampa for 41 years, would you say that consumers in Nampa are very cost-conscious about the money they spend on health insurance?

A. Well, yes, they were.

Q. And you have no reason to believe that has changed, do you?

A. No, I do not.

Q. Mr. Deal, Idaho has recently established a state-based health insurance exchange under the Affordable

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Care Act; is that correct?
A. Correct.
Q. And what state agency in Idaho is responsible for implementation of that health insurance exchange?
A. Well, the legislation that was passed by the Idaho legislature creates an independent board, an exchange board, and it is responsible for the implementation of the exchange.
Q. But isn't the Idaho Department of Insurance involved in that effort?
A. The only effort that the Department of Insurance is involved with is plan management.
Q. Are you aware of what the health insurance exchange is?
A. I certainly am.
Q. When did the exchange become operational?
A. Well, the legislation was passed March 23rd of this year. And the exchange actually went live October 1st, just a few days ago.
Q. Could you explain for the Court what the health insurance exchange is here in Idaho.
A. In very simple terms, the exchange is a marketplace where we have, in Idaho, an open exchange, which means that companies who are authorized to do business in Idaho and wish to participate in the exchange can.

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We ended up with four companies that are providing policies or plans for the exchange. And I call it a one-stop shop from the standpoint that an Idaho citizen can go onto the website and compare prices, learn what their subsidy might be, choose a plan and buy the plan.
Q. And it's true, isn't it, that every plan on the exchange has to offer each of ten specified essential health benefits?
A. Yes.
MR. WILSON: Objection. Leading.
MR. BIERIG: I believe I'm entitled to lead, Your Honor. This is an employee of the plaintiff State of Idaho.
THE COURT: I'd give counsel leeway regardless, so the objection is overruled.
MR. WILSON: And he is not a party, Your Honor.
THE COURT: He is employed by the State of Idaho, who is a party.
MR. WILSON: Excuse me, Your Honor. Which does not mean that every employee of the State of Idaho is an adverse witness.
THE COURT: Well, I tend to view leading questions somewhat differently as long as counsel is not putting words in the witness's mouth. Just to make the matter move more smoothly, I give counsel a fair amount of leeway. But, with that, I will caution counsel not to be putting words in the

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witness's mouth, and then we will have no problem.
Go ahead. The objection is overruled.
MR. BIERIG: I don't think I could put words in this witness's mouth if I wanted, Your Honor. But I do want to reiterate that he is an employee of the plaintiff.
THE COURT: I understand that. I overruled the objection.
BY MR. BIERIG:
Q. So let me repeat the question, Mr. Deal.
It is true, isn't it, that every plan on the exchange must offer ten specified essential health benefits?
A. Yes.
Q. And is it also true that every plan on the exchange must offer four different specified levels of coverage?
A. Well, the answer to that is no. They must provide a silver and a bronze, which means the platinum, in fact, in our exchange is not offered by all of the companies. And the gold is optional, one of the middle plans, too.
Q. So would it be fair to say that each plan that makes an offering on the exchange has to offer these ten essential health benefits and provide at least two levels of coverage?
A. Correct.
Q. And isn't it true that the purpose of offering a

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standardized essential health benefits package is to promote easy comparison of available health plan options based on benefits, price, and quality?
A. Yes.
MR. WILSON: Objection. Leading.
THE COURT: I'm going to -- again, for the record, but I am going to overrule the objection.
BY MR. BIERIG:
Q. What was your answer, Mr. Deal?
A. Yes.
Q. Would you say, as someone who is familiar with the insurance market, that the ability of purchasers of health insurance to compare the prices charged by competing insurance companies for the various levels of the essential health benefits package encourages insurance companies to compete on the basis of price?
A. Yes.
Q. And would you also think that it is fair to say that insurance companies whose products are listed on the exchange will have an incentive to price those products as competitively as possible?
A. Yes.
Q. And in order to do so, won't these insurance companies need to keep their costs as low as possible?
A. I would say so.

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Q. And in order to keep their costs as low as possible, won't insurance companies work hard to keep the costs that they have to pay to providers as low as possible?

MR. WILSON: Objection. Foundation. And this is a direct examination, Your Honor. At some point -- this is a nonhostile witness -- leading questions, in our view, need to stop.

THE COURT: Counsel, again, I tend to view this as being -- it is getting to be a little more leading than what I like. But, on the other hand, he is certainly affiliated with the State of Idaho. He is the head of the Department of Insurance, which is -- although not a party as an agency, the State of Idaho is.

You have a continuing objection, but I am going to allow it. Proceed.

MR. BIERIG: I don't believe we got an answer to the question. Could we have the question read back.

(Question read by reporter.)

THE WITNESS: They have, yes.

BY MR. BIERIG:

Q. And those costs would include the cost of hospital services?

A. Yes, but medical services, yes.

Q. It would also include the cost of physician services?

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A. Yes.

Q. So would you agree that insurance companies will be working very hard to drive down the costs of hospital care in this state?

A. Would I agree? Yes, I would agree.

Q. And would you also agree that insurance companies will be working very hard to drive down the cost of physician services in this state?

A. I would.

Q. And this new exchange will be the first time that consumers in Idaho will have access to a comprehensive one-stop-shop marketplace of information in order to compare the costs of the various plans; is that correct?

A. Correct.

Q. So that whatever incentive they may have had before is even stronger now?

A. Well, clarify the question, please.

Q. So that the transparency of the Idaho Insurance Exchange will provide an even greater incentive to drive down cost; is that not right?

A. We are hoping so.

Q. Mr. Deal, would you agree that Idaho's small population has historically dissuaded insurers from entering the Idaho health insurance market?

A. Well, if you are meaning that some of the large

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carriers do not participate here, I would say yes. We have a good marketplace, however.

Q. Would you agree that more strong entrance in the health insurance marketplace in Idaho is something that you are pleased about?

A. Well, I'm pleased that we have a competitive market and we have insurance companies that want to be competitive and provide a good price for our citizens, yes.

Q. And offering consumers more choice is the result of having -- let me strike that.

And having more entrants into the Idaho health insurance marketplace can offer consumers more choice; is that correct?

A. Well, I would say that, at least my philosophy, more participants should provide more competition.

Q. And that is a good thing for Idahoans?

A. I think so.

Q. Are you familiar, Mr. Deal, with the SelectHealth insurance provider?

A. Yes.

Q. And it is true, isn't it, that SelectHealth only recently began marketing its products in Idaho?

A. Yes.

Q. As the director of the Department of Insurance, were you happy to see the entry of SelectHealth in a more

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active role in the insurance market?

A. Well, I am happy to see companies that want to participate in our market, and certainly we were happy that SelectHealth joined that group.

Q. Wouldn't it be fair to say that you were very happy to see the SelectHealth entry into the market?

A. Well, I am not going to say "very happy," but it was good that they did.

Q. Well, I think you did say you were very happy. Let's just ask the court to put on No. 15.

MR. BIERIG: Can you switch screens, Your Honor?

THE COURT: Yes.

BY MR. BIERIG:

Q. So let's just show this. So let's read: "So were you, as the director of the Department of Insurance, pleased to see the entry of SelectHealth in a more active way to promote competition?"

Answer: "As the director, I was happy to see that we had SelectHealth and we had Altius and then we had this company I can't think of the name of."

A. Altius.

Q. "So, yes" --

A. Yes.

Q. -- "we were very happy."

A. I am very happy.

Q. And I am very happy that you are very happy.
And if SelectHealth were to offer a premium that was lower than other insurers, that would affect the pricing of other insurance companies, would it not?
A. Well, the process that we went through when we were pricing or approving plans for the exchange was that none of the companies knew what the other company did until after all the plans were in and approved by the Department. And if they came back with a low cost, so much the better for SelectHealth, or if some other company did.
So that's -- that's how I see the answer to your question.
Q. Okay.
MR. BIERIG: Let me -- let me ask the Court to put on No. 17, please.
THE COURT: We need page and line number.
MR. BIERIG: Excuse me?
THE COURT: We need a page and line number for the record.
MR. BIERIG: It's page 47, line 18 through 24, Your Honor.
THE COURT: I am afraid we may have missed the last page and line number. Let's go ahead. And perhaps at the end, you can state for the record what the excerpt was that you played just a moment ago.

BY MR. BIERIG:
Q. So it says the question was: "And if SelectHealth were to offer a premium that was lower than Blue Cross, that certainly would affect the pricing of Blue Cross, could it not?"
Answer: "Well, it could, yeah."
Question: "It could [sic] cause Blue Cross to lower its premium to match the competition; correct?"
Answer: "Correct."
You did state that at your deposition, did you not?
MR. WILSON: I'm not sure that is impeaching of his answer here in court today.
MR. BIERIG: I'm just asking whether he agrees with it or does not.
THE COURT: Well, it is not a 30(b)(6) designee on behalf of the State of Idaho, so I'm not sure you can just offer the statement. Although I guess he is an agent and certainly speaking within the area of his authority.
I will overrule the objection. I think it probably could be admitted for substantive purposes beyond cross -- I mean, beyond impeachment.
MR. ETTINGER: Your Honor, I had a slightly different objection. Mr. Bierig, I'm sure inadvertently, said "would" the first time instead of "could." And what's on the screen says "could." It's kind of a substantive

difference.
MR. BIERIG: That's fair enough. So I'll rephrase my question.
THE COURT: If you would.
BY MR. BIERIG:
Q. Would you agree that if SelectHealth were to offer a premium -- keep that on, please -- would you agree that if SelectHealth were to offer a premium that was lower than Blue Cross, that could cause Blue Cross to lower its premium to match the competition? You answered correct. Is that still your view?
A. Well, I would say hypothetically. But the way we did it did not allow another company to lower their rates as we move forward into the exchange.
Q. Right. But, of course, now Blue Cross -- now the exchange figures are published, and certainly other insurance companies will know what SelectHealth is offering; correct?
A. They are published, yes.
Q. And so Blue Cross could certainly adjust its rates going forward, could it not?
A. Yes, but --
MR. WILSON: Objection, Your Honor. This whole line of questioning calls for speculation.
THE COURT: Counsel, I think the witness can, I

guess, speculate in the sense he can offer an opinion as to how things occur within the area of his regulatory responsibility, but I'm not sure these questions fall within that. So I am inclined to agree that perhaps the objection should be sustained.
Why don't we back up. I will allow you to inquire specifically -- I mean, he can offer statements about his understanding of the -- how the Department of Insurance works and its regulatory function. But I think as to how the marketplace works, I think we are either getting into an area that calls for expertise, or it becomes speculation.
So, with that guidance, let's go ahead --
MR. BIERIG: I appreciate it, Your Honor. Except I would note that he is the director of the agency which is responsible for regulating the delivery of insurance in this state. So to say that he doesn't know about these things, I think -- as counsel for State of Idaho was suggesting, I think may not be accurate.
THE COURT: All right. Let's go ahead and proceed.
BY MR. BIERIG:
Q. Mr. Deal, as the director of the Department of Insurance for Idaho, is it your belief that Idaho healthcare providers and insurance companies need to find mechanisms for coordinating care better?

A. I think that's a goal that we have, yes.
Q. In fact, it is your belief, is it not, that insurers and health providers should move toward a system where physicians and health systems are compensated based on outcome as opposed to a fee-for-service model; is that not correct?
A. Yes, I think that's an option, capitation, fee-for-service, outcome-based compensation. There are some alternatives.
Q. Right, there are alternatives. But, in fact, you believe that insurers and health providers should move towards a system where one alternative is to have physicians and health systems compensated based on outcome as opposed to fee-for-service?
A. Yes.
Q. So you would agree that moving toward a model where there is at least an option of an outcome-based system as opposed to a fee-for-service system is a desirable goal?
A. Yes. That is a personal opinion, yes.
Q. Would you agree that if a physician hospital network were trying to move towards a system whereby compensation were based on outcome rather than on volume, that is something that should at least be given an opportunity to demonstrate whether it works or not?
MR. WILSON: Objection. Foundation.

THE COURT: I'm not sure I am tracking.
MR. WILSON: The objection or the question?
THE COURT: Well, the objection. The objection is that it lacks foundation. It calls for the witness's opinion as the regulator. So what is the lack of foundation? What is missing?
MR. WILSON: Mr. Bierig is asking his opinion about what a hospital network might do and whether or not that is consistent with the views he has expressed here about movement towards risk-based contract.
THE COURT: Let's rephrase it in terms of the witness's role as the regulator, director of the Department of Insurance, as opposed to -- I now understand.
Thank you, Mr. Wilson, for clarifying.
I will sustain the objection.
BY MR. BIERIG:
Q. Mr. Deal, as director of the Department of Insurance, which is charged with regulating insurance in the State of Idaho --
THE COURT: Well, but the question was not phrased in terms of that regulatory function, as I understood it. Now, perhaps I misunderstood; but, regardless, I think it needs to be clarified.
MR. BIERIG: Thank you, Your Honor.
THE COURT: Well, just so we are clear. I don't

want to make it more difficult. I am just trying -- I'm suggesting that the question is phrased about what he, as the director of the Department of Insurance, would promote as a policy of the State of Idaho, that's fair game. If the comment is about what a hospital would or should do or what an insurance company would or should do in the abstract, then I think that is objectionable.
MR. BIERIG: I completely agree with that, Your Honor. And I would ask the reporter to read back the question because I think I asked it -- but rather than have her read it back, why don't I ask another question.
THE COURT: That's kind of what I was suggesting, just to make it clear.
MR. BIERIG: I was slow, but I ultimately got there, Your Honor.
THE COURT: All right.
BY MR. BIERIG:
Q. As the director of the department charged with regulating insurance in the state of Idaho, Mr. Deal, if a physician hospital network were trying to move towards a system whereby compensation would be based on outcome rather than volume, is that something that you think should be at least given the opportunity to prove itself?
MR. WILSON: Your Honor, objection. The witness's regulatory responsibilities -- or, rather, those of his

department -- do not involve the regulation of reimbursement rates between providers and insurers, and that is what this questioning goes to.
THE COURT: Mr. Bierig.
MR. BIERIG: This witness is the leading government agent in the State of Idaho on the insurance market. And based on his experience, both as a -- someone who sold insurance for 41 years and as a regulator of the insurance market here in Idaho, I think it is fair to ask him whether he thinks that having a physician hospital network offering a product that is -- that has compensation based on outcome rather than on volume is something that he believes should at least be evaluated.
THE COURT: All right. I am going to allow the witness to answer.
But, Mr. Deal, the question was couched in terms of your role as the director of the Department of Insurance. And if you feel, from your responsibilities, it is irrelevant, you can so indicate. If you think it is a good thing or a bad thing within the context of your regulatory responsibilities, you can answer it.
Do you understand?
THE WITNESS: Yes, sir.
THE COURT: The objection is overruled with that clarification.

THE WITNESS: Thank you, Your Honor.
Well, Your Honor, what we do at the Department of Insurance is regulate the insurance industry, which means agents we license, companies we license.
The question that was asked me was totally an opinion, and it would be my personal opinion. So, to me, it is outside of the authority that we have at the Department of Insurance.
THE COURT: Well, just so it is clear, the fact that it may be your personal opinion, you -- I am not concerned with.
So what I do want to know, though, is whether you have an opinion whether it would have any impact or whether it would be a positive or a negative thing in terms of the areas of regulation for which you have responsibility. And if you don't have an opinion, you can so indicate.
THE WITNESS: I don't have an opinion.
THE COURT: All right.
MR. BIERIG: In that case, I would ask the Court to come up with --
THE COURT: I'm sorry?
MR. BIERIG: This is page 53, lines 2 to 17. Since he says he has no opinion on the subject, I thought we would see if this is accurate. Page 53, lines 2 to 17 of Mr. Deal's deposition. Can you make that a little darker?

BY MR. BIERIG:
Q. So you were asked at your deposition, question: "That if there were a physician hospital network that was trying to offer an alternative whereby it would be compensated based on outcome rather than on fee-for-service, that would be desirable for the state of Idaho?"
Then Ms. Zahn, who is counsel for the State says: "As his personal opinion as the director of the Department of Insurance?"
And I said: "However you want to answer."
And the answer then from Mr. Deal was: "Well, I think it would be better in my personal opinion, but I think it's a direction that should be evaluated. I think that, you know, what we're into really and philosophically is that we've got to find a way that we can help find a way to make healthcare more affordable. And if there are solutions that are unthought of as being thought of now, I think that they have to be evaluated."
Was that your statement in your deposition, Mr. Deal?
A. I did say that.
Q. And do you still agree with that statement?
A. Yes, I will.
Q. Would it be your opinion, in your capacity as director of the Department of Insurance and your desire to do what is best for the State of Idaho, that such a plan

ought to be given a chance to succeed in the marketplace?
A. Yes.
Q. And would you agree that it will take a fair amount of time to see whether a dramatic change in compensation structure will work?
A. Yes.
Q. And why do you say that? Why will it take a fair amount of time?
A. Well, I can tell you that many people have been working on different ways to compensate healthcare providers; and so far, no solution has been found. So I don't think it is an immediate solution to this compensation issue.
Q. So it would be fair to say that to see whether such a plan works will take a fair amount of time?
A. Yes.
Q. Now, Mr. Deal, I think you testified earlier that you are the highest-ranking official in the State of Idaho when it comes to regulation of the insurance market; is that correct?
A. I am the director of insurance.
Q. And in your position as director of the Department of Insurance, you consult and are -- you are consulted by other -- by directors of other departments in the State of Idaho; is that correct?

A. I think a little clarification to the question. I do -- I do consult with other department directors, so the answer would be yes to that part of your question.
Q. Okay. That was really my question.
A. Okay.
Q. And does Governor Otter from time to time seek your advice on insurance-related issues?
A. Yes, he does.
Q. Before the State of Idaho decided to join this litigation against St. Luke's, were you ever contacted by anyone from the Attorney General's Office on your views as to whether this litigation should be brought?
A. No.
Q. Were you contacted by anyone else from the government of the State of Idaho as to whether this litigation should be brought?
A. No.
Q. Were you ever contacted by anyone from the Attorney General's Office about the advisability of the remedy sought by the State of Idaho of divesting Saltzer from St. Luke's?
A. No.
MR. BIERIG: I have no further questions, Your Honor.
THE COURT: Cross.

CROSS-EXAMINATION

BY MR. WILSON:

Q. Good afternoon, Director Deal. Mr. Bierig asked you some questions about the health exchange program here in Idaho. Do you remember those questions?

A. Yes.

Q. Through that exchange, various healthcare insurers offer different metals -- M-E-T-A-L-S -- of plans under the exchange; correct?

A. Yes.

Q. If a healthcare provider wanted to, could it refuse to do business with one of those insurance companies offering plans through the Idaho Health Insurance Exchange?

A. Are we talking about providers?

Q. Right, providers.

A. Yes. There's different networks with different insurance companies, if that is where we are going.

Q. I'm just trying to get -- just because a health insurance company offers a plan through the exchange, that does not mean a provider has to accept that insurance company at its provider location; correct?

A. Correct.

Q. If a provider refused to do business with one of the insurance companies on the exchange, could the Department of Insurance prevent that from happening?

A. No, it can't.

Q. Does the Idaho Department of Insurance have any regulatory role with regard to the negotiation of reimbursement rates between healthcare insurers and healthcare providers?

A. None whatsoever.

Q. Have you ever negotiated a contract on behalf of an insurer with a provider?

A. No.

Q. Would you say that you have any expertise to offer the court today regarding what affects the negotiations between healthcare insurers and providers?

A. No, I don't.

Q. So do you know whether the Idaho Health Insurance Exchange will impact the rates that healthcare providers can negotiate with insurance companies?

A. I don't think so, no.

Q. So are you giving any opinion today about how the Idaho Health Insurance Exchange will impact the prices charged by healthcare providers like St. Luke's?

A. I would say no, but with just a little comment here, is that because the market has changed so drastically because of the preexisting condition exclusion no longer there, it could.

Q. Insurance companies in Idaho have an incentive to

compete on price; correct?

A. Yes.

Q. And that incentive existed before the health insurance exchange; correct?

A. Yes, it did.

Q. And it exists now after the health insurance health exchange; is that correct?

A. It does.

Q. Is that correct?

A. Yes, sir.

Q. Director, do you believe that the insurance market in Idaho is competitive?

A. I do believe it.

Q. Was it competitive before SelectHealth decided to affiliate with St. Luke's?

A. Yes.

Q. Do you know whether adding one more insurer like SelectHealth to the mix necessarily will have any significant impact on the level of competitiveness of the market here in Idaho?

A. I don't know that at this time.

Q. In fact, sitting here today, do you know what the impact has been of SelectHealth on the market for health insurance in Idaho?

A. They have been in the market a short time, and

there is no indication of what that effect is.

Q. Director Deal, have you analyzed the provider network that SelectHealth has offered?

A. No.

Q. Do you know whether Saltzer was in that network before Saltzer was acquired by St. Luke's?

A. I do not.

Q. Do you have any knowledge as to whether the acquisition of Saltzer by St. Luke's will impact the ability of SelectHealth to compete in the market?

A. I don't.

Q. Finally, do you know what evidence the plaintiffs are relying on here to prove their case?

MR. BIERIG: Your Honor, this is way beyond the scope of my direct. I've tried not to object, but --

THE COURT: Sustained. That is such a broad question, Counsel. I mean, it is so broad, I don't know how the witness can answer it, let alone --

MR. WILSON: I am impeaching the witness, Your Honor, that the scope of his knowledge is not relevant to the issues here before the Court.

THE COURT: All right. Rephrase the question. I understand where you are going with that, but perhaps you can rephrase it.

MR. WILSON: Let me just ask one question --

THE COURT: Actually, you probably don't need to rephrase it now that I know what answer you anticipate you are going to get. Let's go ahead and proceed.

BY MR. WILSON:

Q. Do you have any opinion, Director Deal, about what the competitive impact will be of the acquisition of Saltzer by St. Luke's?

A. I do not.

MR. BIERIG: Objection, Your Honor.

MR. WILSON: May I have one moment, Your Honor?

THE COURT: Yes. Well, I am going to overrule the objection. The witness just indicated he has no opinion, so I don't know what purpose there would be in sustaining the objection.

MR. WILSON: Nothing, Your Honor. Nothing further.

THE COURT: Mr. Bierig, redirect?

MR. BIERIG: No further questions, Your Honor.

THE COURT: Director Deal, you may step down. Thank you very much for being here.

Call your next witness. Mr. Schafer, will you be --

MR. SCHAFER: No. Mr. Stein will be calling Dr. Marshall Priest.

THE COURT: Doctor -- is it Priest? Sir, would you come forward, step before Ms. Gearhart, be sworn as a

witness, and then follow her directions from there.

MARSHALL FRANKLIN PRIEST, III,

having been first duly sworn to tell the truth, was examined and testified as follows:

THE CLERK: Please state your complete name and spell your name for the record.

THE WITNESS: Marshall Franklin Priest, III. P-R-I-E-S-T.

THE COURT: You may inquire, Mr. Stein.

DIRECT EXAMINATION

BY MR. STEIN:

Q. Good afternoon, Dr. Priest.

A. Good afternoon.

Q. Would you briefly describe for the court your educational background.

A. I have a bachelor's degree from the University of Tennessee, a master's degree from the University of Tennessee, and a doctor of medicine degree from the University of Tennessee. I completed a medicine internship and residency at the University of Tennessee hospitals in Memphis, and I completed a cardiology fellowship and a junior faculty year at University of Alabama in Birmingham.

Q. Do you hold any board certifications?

A. I do. I am board certified in internal medicine, cardiovascular disease, and interventional cardiology.

Q. What is interventional cardiology?

A. Interventional cardiology is a subspecialty of cardiovascular disease. For an example, I would perform cardiac catheterization, balloon angioplasty, and stent placement in a patient that had a heart attack by opening the blocked artery. That's one example of what an interventional cardiologist would do.

Q. And you are currently an employee of St. Luke's Health System?

A. I am.

Q. What position do you hold within St. Luke's Health System?

A. I am the executive medical director of St. Luke's Heart.

Q. Can you explain to the Court what St. Luke's Heart is.

A. St. Luke's Heart encompasses the cardiovascular service line, which includes cardiologists, vascular surgeons, and cardiac surgeons.

Q. What are your responsibilities as executive medical director of the St. Luke's Heart line?

A. My position is primarily one of leadership. I work in a triad with two other employees: Cy Gearhard, who is the administrator of St. Luke's Heart and currently serving as the interim chief nursing officer; and David

Bishop, who is our practice manager and director of clinics.

In addition, we have responsibility for the pulmonary intensivist group of physicians and the hospitalist group of physicians.

Q. Are there any subcommittees within St. Luke's Heart on which you actively participate?

A. There are a number of subcommittees. I participate as the chair of the quality committee, and I attend meetings of a number of other subcommittees.

Q. Dr. Priest, how long have you been practicing medicine in the state of Idaho?

A. I am in my 35th year of practicing in Idaho.

Q. All of that in Boise?

A. Correct.

Q. And when you moved to Idaho, were you in private practice?

A. I was. I joined a practice then that was known as Boise Cardiology Associates. There were three of us. Two of us left after approximately 18 months and formed the Boise Heart Clinic, which eventually grew to six physicians.

Q. Did you eventually join a group called Idaho Cardiology Associates?

A. I did. I was a founding member of the group in 1994.

Q. And how many doctors founded Idaho Cardiology

Associates?
A. There were six; four of us from Boise Heart Clinic and two independently practicing cardiologists in Boise.
Q. And were you able to grow that practice over time?
A. We were. We grew the practice over a number of years to 16 cardiologists.
Q. So when Idaho Cardiology Associates was an independent practice, at what hospitals did members of the group practice?
A. We practiced both at Saint Alphonsus and at St. Luke's.
Q. So what percentage of the group's work would you say was done at Saint Alphonsus versus St. Luke's when Idaho Cardiology was an independent practice?
A. It varied by individual members of the group. Some members preferred to practice at Saint Alphonsus and would have more work or more of their business at Saint Alphonsus, while others in the group preferred St. Luke's and would have more of their practice based at St. Luke's.
Q. Idaho Cardiology Associates today is affiliated with St. Luke's; is that right?
A. That is correct.
Q. When did that occur?
A. October 1, 2007.
Q. Can you describe generally for the court the

process by which Idaho Cardiology Associates came to be affiliated with St. Luke's.
A. In the fall of 2006, the leadership of Idaho Cardiology approached St. Luke's about developing a more formal relationship, which evolved into an employment agreement. I was not part of that leadership group, but the group in general knew that the leadership group was going to approach St. Luke's about becoming employed.
Q. And so at the time that Idaho Cardiology Associates made the decision to affiliate St. Luke's, there were 16 cardiologists?
A. That's correct.
Q. Did all 16 join St. Luke's?
A. They did not. Twelve joined St. Luke's, and four joined Saint Alphonsus.
Q. So for those of you that affiliated with St. Luke's, when you joined St. Luke's in 2007, did you immediately relinquish your privileges at Saint Alphonsus?
A. We did not. We maintained privileges at Saint Alphonsus until about the first of May, as I recall, in 2008 so that we continued to take call, continued to see patients in the hospital there and provide consultative services.
Q. And why is it that you eventually relinquished your privileges around May of 2008?
A. Our business at Saint Alphonsus declined, not

unexpectedly. I think the physicians there supported the members of the group who had decided to become employed by Saint Alphonsus.
So over a period of time, we felt like we would be more successful by focusing our efforts at St. Luke's. So at the first of May in 2008, we withdrew our privileges. Similarly, the physicians who had become employed at Saint Alphonsus withdrew their privileges from St. Luke's.
Q. Now, at the time that the four Idaho Cardiology Associates doctors left to work at Saint Alphonsus, were there any other cardiologists in the community who practiced primarily at Saint Alphonsus?
A. As I recall, there were three independent cardiologists in addition to those four who were practicing primarily at Saint Alphonsus.
Q. And has Saint Al's been able to grow its cardiology practice since that time?
A. It has. I don't know the exact numbers, but I do, indeed, know they have been successful in recruiting new members to their group. I would estimate the group probably has 12 to 14 members now.
Q. So when Idaho Cardiology Associates first affiliated with St. Luke's back in the fall of 2007, can you describe -- and without getting into the specific figures if you don't need to -- what the general compensation structure

was for the employed cardiologists?
A. Our last -- well, when we were in private practice, we were a fee-for-service organization. When we went to work at St. Luke's, our compensation was then based on a RVU formula, a relative value unit formula.
Q. Generally, what does it mean for the compensation to be primarily RVU-based?
A. It means primarily the more work that you do, the more is your compensation based on the relative value unit of the work.
Q. And so, today, is that still primarily the way that cardiologists employed by St. Luke's are compensated?
A. It's the primary mode of compensation, which has now been flattened. And this has evolved over the period of time that St. Luke's Idaho Cardiology has been at St. Luke's, such that there is now a very large quality component to that compensation package.
Q. So can you describe today the general structure of the way that cardiologists employed by St. Luke's are compensated?
A. Each of the cardiologists receives a flat-figure salary. In addition to that, there is a bucket of incentive money that is based 30 percent on RVU work and 70 percent on quality. That has evolved over the period of time that the cardiology group has been employed at St. Luke's.

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For instance, last year that RVU quality bucket was 50/50. This year it is 30 percent RVU, 70 percent quality, with a plan over the next three years that that bucket will be 100 percent quality.

Q. And when did this new compensation structure that has this substantial quality component go into place?

A. 2011, 2012.

Q. The cardiologists with Idaho Cardiology had been employed by that time for about four years. Why did it take so long to shift from a primarily RVU-based compensation system to one that has a more substantial quality component?

A. This started in the second year of employment when I was still practicing with the group.

For clarification, I haven't been practicing for the group in the two years that I have had my current position as executive medical director.

In the second year of our employment, we developed a St. Luke's Idaho Cardiology centric quality scorecard that included six to eight metrics as sort of an introduction to what a quality scorecard would look like.

Over time that evolved such that, in 2011 and 2012, it included not only metrics related to St. Luke's Idaho Cardiology, but hospital centric metrics as well that incorporated metrics for the vascular surgeons and the cardiac surgeons, such that, today, all of that group -- or

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three groups, excuse me -- of physicians have the same quality scorecard, and the metrics that are followed are transparent across those three groups so that all of the groups are responsible for the quality metrics, not just those that would be centric to their particular group.

Q. When you say "three groups," can you clarify what groups you are talking about?

A. Sure. I meant by that the cardiology group, the vascular surgical group, and the cardiac surgical group.

Q. So does that mean that, for example, if the vascular surgeons don't meet one of their quality criteria, that actually affects the quality component of the compensation for the cardiologists and the cardiac surgeons as well?

A. Correct.

Q. And why is it -- I'm sorry. Do you need to get some water?

A. Please. Thank you.

Q. And why is it that this quality-based compensation is structured that way?

A. The idea is that we are a team. Our whole focus -- excuse me. Our whole focus here is team-based care for cardiac patients, whether they be primarily on the cardiology service, the vascular surgical service, or the cardiac surgical service.

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So, as a team, we are transparent across our subspecialty lines about the care that we are providing so that I have an interest in the care that the cardiac surgeons are providing as though they would have an interest in what the cardiologists are doing.

Q. In this compensation structure we have been discussing, are all of the physicians to whom it applies employees of St. Luke's?

A. They are.

Q. And what role, if any, does the fact that these physicians are employed by St. Luke's play in the ability to move from that primarily RVU-based compensation to the current compensation structure?

A. The group of physicians that I am speaking of here -- and if you will allow me, I will use "group" to mean cardiac surgeons, vascular surgeons, and cardiologists -- are aligned with St. Luke's goal of trying to transform healthcare from a volume-based metric to a value-based metric.

I think most of us recognize that healthcare as it exists in the country right now is not sustainable over time. Accordingly, this group of physicians wanted to link their incentives to the organizational strategies of St. Luke's, which is bending this volume-to-value curve.

Q. Do you think that you would have been able to have

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implemented this new compensation structure if the physicians with the heart line were not employed by St. Luke's?

A. I think it would have been very difficult because of an experience that we had a few years ago when we did have a nonemployed group of cardiologists working at St. Luke's who did not embrace the changes that I am speaking of and subsequently elected to leave St. Luke's and become employed at Saint Alphonsus.

Q. Now, Dr. Priest, you are familiar with Triple Aim?

A. Yes.

Q. And one of the aims of Triple Aim is better health?

A. Yes.

Q. What does that mean to you?

A. Better health refers to population health. You know, conceptually, we are fantastic at rescue care, but we are not very good at preventive/maintenance care, and we never have been.

But in this new healthcare model that we are heading into, the new healthcare environment, preventive care and health maintenance is going to become very important. And we think that where we want to go is to risk modeling so that we have the responsibility of taking care of populations of patients who are at risk for

hospitalizations. The idea is to keep them out of the hospital.

So better health means population health, and that is what we are trying to learn how to do right now.

Q. Can you provide the court with an example of something that the St. Luke's Heart line is doing to promote the aim of better health?

A. We have a congestive heart failure clinic that is directed by Dr. Andrew Chai. To my knowledge, Dr. Chai is the only cardiologist in the state who is board certified in heart failure.

Dr. Chai gave up a very traditional, very busy invasive cardiology practice to direct this congestive heart failure clinic.

On his team are five mid-levels, physician assistants, and nurse practitioners who are totally devoted to the management of congestive heart failure patients.

In addition, we have two nurse navigators who are part of that team and part of our transition of care team who visit these very high-risk congestive heart failure patients in their homes.

The goal of those recurring visits is to assess their social situation; to learn if they have a way to get to their appointments; to learn if they understand what their medicines are, what they are taking them for, why they

are taking them, time of day and evening that they are taking them; and to look in their pantry, see what sort of foods they have there. Do they have high-sodium foods that would put them at risk for redevelopment of heart failure?

So the idea is to try and manage this high-risk population of patients in our clinics and in their homes and keep them out of the emergency department and out of the hospital.

Q. And is this congestive heart failure clinic, is this something that is a profitable endeavor for St. Luke's financially?

A. It is not profitable. In fact, were we a private practice group, there would have been no way we could have afforded to do this.

For an example, every month the advanced heart failure team from Intermountain Healthcare in Salt Lake City flies to Boise and attends this clinic with our clinic team. The purpose of that visit is to identify those very high-risk patients who would be potential candidates for heart transplantation or the implantation of a left ventricular assist device. St. Luke's foots the bill for those folks to come up every month and visit with our heart failure team.

Secondly, Dr. Chai's compensation based purely on an RVU basis would have plummeted, giving up his very busy hospital practice to run this clinic.

Thirdly, there would have been no way as a private practice group that we could have supported five mid-level providers to be completely devoted to the management of patients with congestive heart failure.

Q. And is Dr. Chai one of the physicians whose compensation has gone now from primarily RVU-based to a combination of a fixed salary and a quality component?

A. Correct.

MR. STEIN: Your Honor, I have no further questions at this time.

THE COURT: Counsel, unless we have just very limited questions, we are a little past where we take the evening break.

MR. ETTINGER: Your Honor, it will be me, and I have more than very limited questions.

THE COURT: All right. We will take it up tomorrow morning.

Dr. Priest, I apologize for having to bring you back tomorrow. Unfortunately, it is probably unavoidable. So we'll take it up tomorrow morning at 8:30.

Counsel, we do have the hearing at 3:30. I assume we will just have some representatives here to take that matter up. Other than that, I don't think we have anything else.

MR. BIERIG: A few very quick items, Your Honor. I believe I failed to state for the court the exact page and

line numbers of the "very happy" comment by Mr. Deal. So I would state that that is page 43, line 21 through page 44, line 2 of his deposition.

THE COURT: Thank you.

MR. BIERIG: Also, if I may approach Ms. Gearhart, I would give full Exhibit 2460.

THE COURT: Perhaps, Mr. Metcalf, you can help us out there.

And is there -- did we publish -- I think we were short a deposition that needed to be published.

Ms. Gearhart, is that correct?

MS. GEARHART: Yes.

MR. BIERIG: I'll take whatever you don't need.

THE COURT: Counsel, could you provide the original of Mr. Deal's and Ms. Richards' depositions, since I think they were both used and we need to publish them. Do so this evening so we can take care of that first thing tomorrow morning.

Counsel, is there anything else?

MR. BIERIG: Nothing, Your Honor.

THE COURT: All right. We will be in recess until 8:30 tomorrow morning. We will see some of you back here at 3:30. Court will be in recess.

(Court recessed at 2:35 p.m.)

REPORTER'S CERTIFICATE

I, Lisa K. Yant, Official Court Reporter, County of Ada, State of Idaho, hereby certify:

That I am the reporter who transcribed the proceedings had in the above-entitled action in machine shorthand and thereafter the same was reduced into typewriting under my direct supervision; and

That the foregoing transcript contains a full, true, and accurate record of the proceedings had in the above and foregoing cause, which was heard at Boise, Idaho.

IN WITNESS WHEREOF, I have hereunto set my hand October 11, 2013.

-s-

Lisa K. Yant
Official Court Reporter
CSR No. 279